Appendix I: Study Requests

- CEO/Administrator selection to participate letter
- A list of required documents

September 14, 2007

Dear CEO/Administrator

You have been randomly selected to participate in a study entitled, "**Comprehensive Description of the Peer Review Process in California**", being conducted on behalf of the **Medical Board of California** (MBC) and the **California Legislature** through **SB 231** (Figueroa) (http://leginfo.ca.gov/pub/05-06/bill/sen/sb_0201-0250/sb_231_bill_20051007_chaptered.pdf). The purpose of the study is to evaluate the peer review process and Business and Professions Code Sections 805, 809, and 821.5, as required by the legislation. The requirement is to evaluate peer review in the following four types of entities: 1) Licensed healthcare facilities/clinics, 2) Healthcare service plans. 3) Professional societies, and 4) Medical groups. Included in this packet is a letter from the MBC introducing **Lumetra**, a healthcare consulting company (http://www.lumetra.com/ and http://lumetra.com/programs/index.aspx?id=2808), which will be conducting the study.

The legislation requires that an independent organization, commissioned by the MBC, complete a comprehensive review of documentation related to the peer review process in specific organizations and that selected members of the organization participate in surveys, document retrieval, and web-based focus groups related to peer review. Please find included in this letter a **list of documents** related to the peer review procedure in your organization that we are requesting you provide to Lumetra. Please be assured that Lumetra will protect the confidentiality of your documents and that our report will include only data in the aggregate. No individual organization will be identified.

Please direct this list to the person or persons in your organization most suited to provide the information. That may include the chair of the peer review committee, a well-being committee, a quality control/assessment/assurance committee, and/or the department of quality control/management/assurance. Thank you in advance for your participation. We recognize this is an inconvenience. Our goal is to use your valuable

information to assist the MBC and the Legislature to ensure that California's citizens are given the best healthcare possible. We require that the documents be mailed to Lumetra **no later than November 19, 2007**. Additionally, please provide an organization contact person including name, telephone number, and email address for further data collection. Contact Dr. Jean Ann Seago at the address below with any questions or concerns.

Sincerely,

Pat Daniel
Vice President Medical Review

Jean Ann Seago, PhD, RN
Project Consultant
Voice: 415-677-2160
Email: jseago@lumetra.com

List of Required Documents

In order to understand the peer review process, we require documents from any/all peer review bodies in your organization. A peer review body can be defined as, "A committee organized by any entity that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity". We are specifically evaluating peer review bodies that review physicians and surgeons, doctors of podiatric medicine, clinical psychologists, marriage and family therapists, clinical social workers, or dentists. Peer review bodies may go by various names that may include but are not limited to quality assurance, quality improvement, peer review, or the well-being committee. Please submit the following documents for each peer review body in your organization.

1. Charters
2. Bylaws
3. Policies and Procedures
4. Minutes and agendas for the last 5 years
5. All peer review reporting forms with any definition of terms used
6. Using the Table 2 template (following page), a list of all peer reviewed cases (include medical record numbers and description of circumstances) that have come to your attention.
    a. Please indicate which cases were reported to the Medical Board of California and which were not reported.
    b. Please indicate your rationale for deciding to NOT report a case to MBC.

Please indicate on Table 1 if the document is not applicable to a peer review body in your organization. Documents can be either mailed or sent electronically to Dr. Seago at the address listed below. If you have any questions, please email or telephone:

Dr. Jean Ann Seago
Lumetra
One Sansome Street
San Francisco, CA 94104
415-677-2160 (voice)
(415) 677-2195 (fax)

jseago@lumetra.com

Table 1
Documents from each Peer Review Body

Required Documents	Provided Yes/No	Not applicable to this organization
Charters		
Bylaws		
Policies		
Procedures		
Minutes/Agendas Sept 2002-Sept 2007		
Peer review reporting forms with definitions		
Table of peer reviewed cases Sept 2002-2007		

Table 2
Template for Peer Review Cases for years Sept 2002-Sept 2007

Date of Incident or Complaint	Provider	Potential Type of Review (805 or 821.5)*	Medical Record Number	Patient age, gender, ethnicity	Circumstances of the peer review	Reported to MBC Yes/No	If No, Specific Reason/s for not reporting to MBC	If Yes, Date reported to MBC

- 805 report-"Medical disciplinary cause or reason" means that aspect of a provider's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
- 821.5-investigation of a physically or mentally disabled provider

809.2. If a licentiate timely requests a hearing concerning a final proposed action for which a report is required to be filed under Section 805, the following shall apply:

(a) The hearing shall be held, as determined by the peer review body, before a trier of fact, which shall be an arbitrator or arbitrators selected by a process mutually acceptable to the licentiate and the peer review body, or before a panel of unbiased individuals who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the same matter, and which shall include, where feasible, an individual practicing the same specialty as the licentiate.

(b) If a hearing officer is selected to preside at a hearing held before a panel, the hearing officer shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

(c) The licentiate shall have the right to a reasonable opportunity to voir dire the panel members and any hearing officer, and the right to challenge the impartiality of any member or hearing officer. Challenges to the impartiality of any member or hearing officer shall be ruled on by the presiding officer, who shall be the hearing officer if one has been selected.

(d) The licentiate shall have the right to inspect and copy at the licentiate's expense any documentary information relevant to the charges which the peer review body has in its possession or under its control, as soon as practicable after the receipt of the licentiate' s request for a hearing. The peer review body shall have the right to inspect and copy at the peer review body's expense any documentary information relevant to the charges which the licentiate has in his or her possession or control as soon as practicable after receipt of the peer review body's request. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable licentiates, other than the licentiate under review. The arbitrator or presiding officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires.

(e) When ruling upon requests for access to information and determining the relevancy thereof, the arbitrator or presiding officer shall, among other factors, consider the following:

(1) Whether the information sought may be introduced to support or defend the charges.

(2) The exculpatory or inculpatory nature of the information sought, if any.

(3) The burden imposed on the party in possession of the information sought, if access is granted.

(4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(f) At the request of either side, the parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least 10 days before the commencement of the hearing shall constitute good cause for a continuance.

(g) Continuances shall be granted upon agreement of the parties or by the arbitrator or presiding officer on a showing of good cause.

(h) A hearing under this section shall be commenced within 60 days after receipt of the request for hearing, and the peer review process shall be completed within a reasonable time, after a licentiate receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges, unless the arbitrator or presiding officer issues a written decision finding that the licentiate failed to comply with subdivisions (d) and (e) in a timely manner, or consented to the delay.

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Appendix II: Survey and Focus Group Questions

- Peer Review Survey: Peer Review Body Chair Survey - A
- Peer Review Survey: Physician Reviewer Survey - B
- Peer Review Survey: Physician Was Reviewed Survey - C
- Peer Review Survey: Non-Physician Organization Staff Survey - D
- Peer Review Survey: Attorney Representing Organization Survey - E
- Peer Review Survey: Attorney Represented Physician Survey - F
- Questions for MBC Staff Members
- Focus Group Questions

Peer Review Survey
Peer Review Body Chair Survey – "A"

As part of the Medical Board of California Comprehensive Study of the Physician and Surgeon Peer Review Process Project, we are asking that people who serve in various roles in an organization's Peer Review Process complete this survey. The answers to the questions will provide us with information about the individual's understanding, experience, and opinions of the organization's Peer Review Process. Thank you for your willingness to answer these questions.

Please provide the following information related to peer review in your organization. If peer review activities are performed by multiple committees, please respond based on your knowledge of the committee in which you are involved.

Please select your best response without additional consultation or collecting further data. Be assured that your responses will remain confidential. All the data will be in the aggregate and no individual or organization will be identified. If you have any questions about the survey or the report, please contact:

Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
jseago@lumetra.com
415-677-2160 voicemail
415-677-2185 fax

If you would like to review additional information regarding this project, you can refer to the website: www.lumetra.com/mbc.

1. Organization # (If you do not know your #, contact Dr. Seago or your organization contact person)

2. Organization Type
   - Hospital
   - Medical Group
   - Health Plan
   - Professional society

3. Identify your position in the organization related to Peer Review.
   A - Peer Review Body Chair
   B - Physician reviewer for the organization
   C - Physician who has been reviewed
   D - Non-physician organization staff
   E - Attorney who has represented the organization in a peer review
   F - Attorney who has represented a physician being reviewed

4. Please identify your title in the Peer Review Body.
   - Chair
   - Director
   - Administrator
   - President
   - Other (please specify)

5. The major/final Peer Review Body in this organization is called: (check all that apply)
   - Care Review committee

- Credentialing committee
- Licensing/Credentialing committee
- Medical Department committee/s
- Medical Staff Executive committee
- Peer review committee
- Pharmaceutical committee which manages adverse drug effects
- Professional Affairs committee
- Quality committee (Quality Improvement committee)
- Risk Management committee
- Utilization committee
- Well-being committee
- Other (please specify)

6. Total number (#) of members
7. Number (#) of committee members who are non-physician staff
8. Number (#) of disciplines represented besides medicine (nursing, medicine, pharmacy, etc)
9. Number (#) of different medical specialties represented(surgery, pediatrics, etc)
10. Number (#) of committee members who are generalists

11. What are the types of specialties that are represented on the committee? (check all that apply)
    - Anesthesiology
    - Emergency Medicine
    - Family Practice
    - IM subspecialty - Pediatric subspecialty
    - Internal Medicine
    - OB/Gynecology
    - Psychiatry
    - Radiology
    - Surgery
    - Pediatrics
    - Other (please specify)

12. Schedule of committee meetings: How often does this peer review body meet?
    - Monthly
    - Quarterly
    - Bi-weekly
    - Bi-annually (every 6 months)
    - Other (please specify)

13. Indicate the methods used in recruiting members to the Peer Review Body: (check all that apply)
    - Payment is offered by organization
    - Requirement for affiliation/employment
    - Requirement for hospital privileges
    - Experience in peer review
    - Interest in peer review
    - Willingness to serve
    - Scheduled/rotating obligation
    - Other Indicate 'other' methods:
    - None of the above

14. Is committee composition determined by any of the following: (check all that apply)
    - A specific percentage of physician specialists (ex: orthopedists, pediatricians, etc.)
    - A specific percentage of physician generalists (ex: primary care or family practice, etc.)
    - A specific percentage of mid-level providers (ex: nurse practitioners, physician assistants, certified registered, nurse assistants, midwives, etc.)
    - A specific percentage of non-physicians (registered nurses, therapists, social workers, etc.)
    - None of the above
    - Other (please specify)

15. What is the usual term for each member who serves on the peer review body?
    - 1 year
    - 2 years
    - More than 2 years
    - Other (please specify term)

16. In the last calendar year, how many new members were added to the peer review body?

17. In the last calendar year, how many individuals were approached to serve on a peer review body?

18. If applicable, of those approached, how many refused?

19. Indicate reasons for non-participation.
    - N/A
    - Too busy
    - Interferes with practice
    - Do not like to judge colleagues
    - Other (please specify)

20. In the last calendar year, how many unanticipated member changes have occurred in the peer review body?

21. If applicable, indicate the reason(s) for the changes.
    - Term expired
    - Member moved out of the area
    - Member retired
    - Moved practice
    - Dropout
    - If 'other' reasons, specify:

22. Indicate responsibilities of the peer review body: (check all that apply)
    - Quality of care concern (evaluate)
    - Utilization of care (evaluate)
    - Initial screening for patient care issue related to an organizational or systems-problem
    - Initial screening for patient care issue related to a physician's practice
    - Sentinel event
    - A physician's practice pattern
    - Series of complaints/events about physician
    - Secondary or final determination of action, if any, to be taken for a patient care issue related to a physician's practice
    - Tracking or monitoring of a physician's practice issue
    - Submit an 805 report
    - Submit an 821.5 report
    - Convene or oversight of an 809 hearing
    - Other If 'other' responsibilities, specify:

23. In your organization, indicate circumstances or criteria for which an 805 or 821.5 report WOULD BE CONSIDERED: (check all that apply) A: INITIAL MECHANISMS in your organization by which potential 805 or 821.5 issues are identified (an 805 report is a peer review body action taken for medical disciplinary cause or reason; an 821.5 report is action taken related to a physician's disabling mental or physical condition): B: Criteria/circumstances used to determine whether an issue is taken to a SECONDARY or HIGHER LEVEL REVIEW body in your organization:

Reason	A Initial Mechanisms	B Secondary Review
Patient complaint		
Multiple patient complaints		
Provider (mid-level/physician) complaint		
Multiple provider (mid-level/physician) complaints		
Nurse or other hospital employee complaint		
Multiple nurse or other hospital employee complaints		
Health plan complaint		
Multiple health plan complaints		
Quality program screening issue		
Utilization program screening issue		
Peer Review Committee screening issue required for the IPA, Health Plan membership, and/or hospital affiliation		
Risk management committee screening issue		
Provider practice pattern that is not consistent with the general standards of care		
Repeated allegations or errors in the delivery of care		
Potentially gross and flagrant care that endangers patient		
Egregious/sentinel event		
Malpractice case		
Arbitration/Mediation case		
Limitation or restriction of practice		
Required proctoring		
Other If 'other' criteria, specify and state for either scenario A or B above:		

24. Indicate the **position** of the person, committee, or mechanism that determines whether to refer an issue to a secondary or higher review body in the organization: (check all that apply)

- Chair of initial screening committee
- A majority vote of the initial screening committee
- Peer review chair
- Organization policies & procedures
- Medical Department Chair
- A majority vote of the Medical Department members
- Professional Affairs Committee decision
- Credentialing Committee decision
- Risk Management Committee decision
- For 'other' position(s), specify.

25. In your organization, indicate the **criteria** used to determine whether a case is REPORTED (805 or 821.5) to the Medical Board of California (MBC): (check all that apply)
    - Patient complaint
    - Multiple patient complaints
    - Provider (mid-level/physician) complaint
    - Multiple provider (mid-level/physician) complaints
    - Nurse or other hospital employee complaint
    - Multiple nurse or other hospital employee complaints
    - Health plan complaint
    - Multiple health plan complaints
    - Quality program screening issue
    - Utilization program screening issue
    - Peer Review Committee screening issue for the IPA, Health Plan membership, and/or hospital affiliation
    - Risk management committee screening issue
    - Provider practice pattern that is not consistent with the general standards of care or evidence-based medicine
    - Repeated allegations or errors in the delivery of care
    - Potentially gross and flagrant care
    - Egregious/sentinel event
    - Malpractice case
    - Arbitration/Mediation case
    - Limitation or restriction of practice
    - Required proctoring
    - Other For 'other' criteria, specify.

26. Indicate the **person, committee, or mechanism** that determines whether an issue (805 or 821.5) is reported to the Medical Board of California (MBC): (check all that apply)
    - Chair of secondary or final determination committee
    - A majority vote of the final review committee
    - Peer review chair
    - Organization policies & procedures
    - Medical Department Chair
    - A majority vote of the Medical Department members
    - Professional Affairs Committee decision
    - Credentialing Committee decision
    - Risk Management Committee decision
    - Other For 'other' person(s)/committee, specify.

27. After a reportable event (805 or 821.5), the organization's designated peer review officer must submit a report to the relevant agency within:
    - 1 - 15 days
    - 16 - 30 days
    - 31 - 45 days
    - Other (specify estimate number of days)

28. After the licentiate has satisfied the terms of a disciplinary action, a supplemental report is made to the relevant agency within:
    - 1 - 30 days
    - 31 - 60 days
    - 61 - 90 days
    - Other (specify estimate number of days)

29. After initiating a formal investigation of a potential 821.5 event, the organization's designated peer review officer must submit a report within:
    - 1 - 15 days
    - 16 - 30 days
    - 31 - 45 days
    - Other (specify estimate range of days)

30. Upon receipt of an 821.5 report, the MBC diversion program administrator shall contact the reporting peer review body within:
    - 1 - 60 days
    - 61 - 90 days
    - 91 - 120 days
    - Other (specify estimate range of days)

31. Indicate the criteria used for filing/not filing an 805 report: (check all that apply)
    - When a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason
    - When a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges, or employment
    - When a peer review body imposes or a licentiate oluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason
    - After notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason
    - Resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership
    - The imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days
    - Other For 'other' criteria, specify.

32. Indicate the **criteria** used for filing an 821.5 report for a physician or surgeon POSING A THREAT TO PATIENT CARE: (check all that apply)
    - Physician or surgeon suffering from a disabling mental condition
    - Physician or surgeon suffering from a disabling physical condition
    - Physician or surgeon suffering from a substance abuse condition
    - Other For 'other' criteria, specify.

33. For either the 805/821.5 report, identify the **resources** available to assist you in your determination for filing: (check all that apply)
    - Websites
    - Discussions with licensing authorities
    - Review of 805/821.5 legal codes
    - Organization documents
    - None
    - Other For 'other' resources, specify:

34. In the last calendar year, estimate the **TOTAL AMOUNT** of time **IN HOURS** spent (including preparation, meetings, etc.) by the following staff for all actual or potential 805 or 821.5 issues reviewed by the Peer Review Body: organization staff (i.e., managers, committee members, and administrators) physician staff

Time	Organizational Staff	Physician staff
0-250 hours		
251-500 hours		
501-1000 hours		
1000-3000 hours		
greater than 3000 hours		

35. In the last calendar year, estimate the TOTAL COST IN DOLLARS ($) spent by the organization on the 805 or 821.5 peer review process, including legal fees and all other time and staffing costs.
    - $ 0-50,000
    - $ 50,001-250,000
    - $ 250,001-500,000
    - $ 500,000-1,000,000
    - greater than $1,000,000

36. Please list the reasons of the highest three costs.

37. In the last calendar year, estimate the AMOUNT OF **TIME IN HOURS** spent **IN EACH PHAS**E OF (for preparation of, during the process of, and for monitoring/tracking after) an 805 or 821.5 report proceedings. Proceedings are activities conducted by peer review bodies. This includes aggregate time for the involvement of staff, physician reviewers, legal advisers, and administrators, as well as preparation by physicians or midlevel providers who are being reviewed.

Time Amount	PREPARATION	DURING	MONITORING
0-250 hours			
251-500 hours			
501-1000 hours			
1000-3000 hours			
greater than 3000 hours			

38. For the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS spent by the organization on 809 hearings:
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours
    - greater than 3000 hours

39. For the last calendar year, estimate the TOTAL COST IN DOLLARS ($) spent by the organization on 809 hearings:
    - $ 0-50,000
    - $ 50,001-250,000
    - $ 250,001-500,000
    - $ 500,000-1,000,000
    - greater than $1,000,000

40. For the typical calendar year, how has the amount spent by the organization on 809 hearings varied from the last calendar year?
    - Less than the last calendar year
    - More than the last calendar year
    - Same amount as the last calendar year

Rate the following question on a scale of 1-5, with 1 being the least likely and 5 being the most likely, in your organization. (note: “political” is defined as being used for purposes other than intended, such as discrimination based on ethnicity or gender, or to remove a competitor)

41. How likely is it that 805 reporting is used for “political” reasons?

42. If you have experienced or are aware of 805 reporting used for reasons other than intended (ensuring patient safety), please list the reasons.

Rate the following question on a scale of 1-5, with 1 being the least confident and 5 being the most confident.

43. How confident are you that action will be taken by the MBC once an 805 report has been filed?

Rate the following question on a scale of 1-5, with 1 being the least difficult and 5 being the most difficult.

44. What is the level of difficulty (eg. user-friendliness, clear documentation) for using the MBC's current 805 reporting forms?

45. List your recommendations for changes to the 805 reporting forms to make them more user-friendly and clear:

46. Have you been involved in an 809 hearing?
    - Yes
    - No

Rate the following question on a scale of 1-5, with 1 being the least efficient and 5 being the most efficient.

47. How efficient (in relation to timeliness and duration) was the 809 hearing process?

Rate the following question on a scale of 1-5, with 1 being the least effective and 5 being the most effective.

48. How effective (ensuring individual rights and that the process was followed) was the 809 hearing process?

49. Identify requirements of 809 hearings: (check all that apply)
    - An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the matter
    - The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer
    - The right of the licentiate to inspect and copy relevant documents
    - The parties shall exchange lists of witnesses at the request of either side
    - Commencing a hearing within 60 days after receipt of the request
    - None of the above

50. Indicate all obstacles applicable to each type of reporting (805 and 821.5) that you have experienced or would predict: (check all that apply)

Obstacle	805 reporting	821.5 reporting
N/A		
Reluctance to take action against friend/colleague		
Fear of being sued for restricting trade of a competitor		
Reluctance to take action because of potential for retribution		
Organization uses "internal punishment" (resignation, practice restriction) to reduce reporting		
Organization encourages an "administrative resolution" (MD agrees to resign in exchange for the organization not filing a report)		
No obstacles		
Other For 'other' obstacles, specify and indicate type of reporting (805 or 821.5):		

51. Indicate your recommendations to avoid the above obstacles: (check all that apply)
    - Peer review to be completed by physicians outside the geographic area
    - Independent body conducts the peer review (independent of the organization)
    - Nonlicensing body conducts the peer review (independent of state agencies)
    - No changes necessary
    - Other For 'other' recommendations, specify.

52. Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.
    - No changes necessary
    - Eliminate peer review
    - Create a statewide government entity that conducts peer review
    - Create a statewide government entity that controls credentialing (not just licensing)
    - Hire an independent organization (non-government) to manage and conduct a peer review
    - Other For 'other' recommendations, specify:

53. In your organization, if repeated allegations are raised against a particular provider, would the organization allow this provider to maintain their practice privileges?
    - Yes
    - No

54. Please identify potential reasons the organization would allow a provider with repeated allegations raised against them to maintain their practice privileges? (check all that apply)
    - N/A
    - The provider brings in a large amount of revenue
    - The provider admits many patients
    - The provider is the only specialist of a specific type in the geographic area
    - The provider has been with the organization for many years
    - The organization cannot find a replacement
    - The organization would not allow such a provider to practice
    - Other If 'other' reasons, specify.

Peer Review Survey
Physician Reviewer Survey – "B"

As part of the Medical Board of California Comprehensive Study of the Physician and Surgeon Peer Review Process Project, we are asking that people who serve in various roles in an organization's Peer Review Process complete this survey. The answers to the questions will provide us with information about the individual's understanding, experience, and opinions of the organization's Peer Review Process. Thank you for your willingness to answer these questions.

Please provide the following information related to peer review in your organization. If peer review activities are performed by multiple committees, please respond based on your knowledge of the committee in which you are involved.

Please select your best response without additional consultation or collecting further data. Be assured that your responses will remain confidential. All the data will be in the aggregate and no individual or organization will be identified. If you have any questions about the survey or the report, please contact:

Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
jseago@lumetra.com
415-677-2160 voicemail
415-677-2185 fax

If you would like to review additional information regarding this project, you can refer to the website: www.lumetra.com/mbc.

37. Organization # (If you do not know your #, contact Dr. Seago or your organization contact person)

38. Organization Type
    - Hospital
    - Medical Group
    - Health Plan
    - Professional society

39. Identify your position in the organization related to Peer Review.
    A - Peer Review Body Chair
    B - Physician reviewer for the organization
    C - Physician who has been reviewed
    D - Non-physician organization staff
    E - Attorney who has represented the organization in a peer review
    F - Attorney who has represented a physician being reviewed

4. The major/final Peer Review Body in this organization is called: (check all that apply)
    - Peer review committee
    - Medical Department committee/s
    - Medical Staff Executive committee
    - Credentialing committee
    - Well-being committee
    - Quality committee (Quality Improvement committee)
    - Utilization committee
    - Licensing/Credentialing committee
    - Professional Affairs committee

- Pharmaceutical committee which manages adverse drug effects
- Risk Management committee
- Care Review committee
- Other (please specify)

5. Indicate the methods used in recruiting members to the Peer Review Body? (check all that apply)
    - Payment is offered by organization
    - Requirement for affiliation/employment
    - Requirement for hospital privileges
    - Experience in peer review
    - Interest in peer review
    - Willingness to serve
    - Scheduled/rotating obligation
    - Other If 'other' method(s), specify:

6. Identify the reason(s) you agreed to serve on the Peer Review Body? (check all that apply)
    - Payment is offered by organization
    - Requirement for affiliation/employment
    - Requirement for hospital privileges
    - Experience in peer review
    - Interest in peer review
    - Willingness to serve
    - Scheduled/rotating obligation
    - Other If 'other' reason(s), specify:

7. Indicate the criteria used for filing/not filing an 805 report: (check all that apply)
    - when a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason.
    - when a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges, or employment.
    - when a peer review body imposes or a licentiate voluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason.
    - after notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason
    - resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership.
    - the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.
    - Other For 'other' criteria, specify.

8. For the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS (preparation, meetings, etc.) you spent related to your work as a physician reviewer of the organization:
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours
    - greater than 3000 hours

9. For the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS you spent as a physician reviewer of the organization on 809 hearings:

- 0-250 hours
- 251-500 hours
- 501-1000 hours
- 1000-3000 hours
- greater than 3000 hours

Rate the following question on a scale of 1-5, with 1 being the least likely and 5 being the most likely, in your organization. (note: "political" is defined as being used for purposes other than intended, such as discrimination based on ethnicity or gender, or to remove a competitor)

10. How likely is it that 805 reporting is used for "political" reasons?

11. If you have experienced or are aware of 805 reporting used for reasons other than intended (ensuring patient safety), please list the reasons.

    Rate the following question on a scale of 1-5, with 1 being the least confident and 5 being the most confident.

12. How confident are you that action will be taken by the MBC once an 805 report has been filed?

13. Have you been involved in an 809 hearing?
    - Yes
    - No

    Rate the following question on a scale of 1-5, with 1 being the least efficient and 5 being the most efficient.

14. How efficient (in relation to timeliness and duration) was the 809 hearing process?

    Rate the following question on a scale of 1-5, with 1 being the least effective and 5 being the most effective.

15. How effective (ensuring individual rights and that the process was followed) was the 809 hearing process?

16. Identify requirements of 809 hearings: (check all that apply)
    - An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the matter.
    - The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer.
    - The right of the licentiate to inspect and copy relevant documents.
    - The parties shall exchange lists of witnesses at the request of either side.
    - Commencing a hearing within 60 days after receipt of the request.
    - None of the above

17. Please include any problems you have experienced with the procedure. Indicate your recommendations to avoid the above obstacles: (check all that apply)
    - Peer review to be completed by physicians outside the geographic area
    - Independent body conducts the peer review (independent of the organization)
    - Nonlicensing body conducts the peer review (independent of state agencies)
    - No changes necessary

- Other For 'other' recommendations, specify.

18. Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.
    - No changes necessary
    - Eliminate peer review
    - Create a statewide government entity that conducts peer review
    - Create a statewide government entity that controls credentialing (not just licensing)
    - Hire an independent organization (non-government) to manage and conduct a peer review
    - Other For 'other' recommendations, specify:

19. In the organization that you work for as a physician reviewer, if repeated allegations are raised against a particular provider, would the organization allow this provider to maintain their practice privileges?
    - Yes
    - No

20. Please identify potential reasons that the organization that you work for as a physician reviewer would allow a provider with repeated allegations raised against them to maintain their practice privileges? (check all that apply)
    - N/A
    - The provider brings in a large amount of revenue
    - The provider admits many patients
    - The provider is the only specialist of a specific type in the geographic area
    - The provider has been with the organization for many years
    - The organization cannot find a replacement
    - The organization would not allow such a provider to practice
    - Other If 'other' reasons, specify.

Peer Review Survey
Physician Was Reviewed Survey – "C"

As part of the Medical Board of California Comprehensive Study of the Physician and Surgeon Peer Review Process Project, we are asking that people who serve in various roles in an organization's Peer Review Process complete this survey. The answers to the questions will provide us with information about the individual's understanding, experience, and opinions of the organization's Peer Review Process. Thank you for your willingness to answer these questions.

Please provide the following information related to peer review in your organization. If peer review activities are performed by multiple committees, please respond based on your knowledge of the committee in which you are involved.

Please select your best response without additional consultation or collecting further data. Be assured that your responses will remain confidential. All the data will be in the aggregate and no individual or organization will be identified. If you have any questions about the survey or the report, please contact:

Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
jseago@lumetra.com
415-677-2160 voicemail
415-677-2185 fax

If you would like to review additional information regarding this project, you can refer to the website: www.lumetra.com/mbc.

40. Organization # (If you do not know your #, contact Dr. Seago or your organization contact person)

41. Organization Type
    - Hospital
    - Medical Group
    - Health Plan
    - Professional society

42. Identify your position in the organization related to Peer Review.
    A - Peer Review Body Chair
    B - Physician reviewer for the organization
    C - Physician who has been reviewed
    D - Non-physician organization staff
    E - Attorney who has represented the organization in a peer review
    F - Attorney who has represented a physician being reviewed

4. Indicate the criteria used for filing/not filing an 805 report: (check all that apply)
    - when a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason.
    - when a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges, or employment.
    - when a peer review body imposes or a licentiate voluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason.
    - after notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason

- resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership.
- the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.
- Other For 'other' criteria, specify.

5. In the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS you lost from practice in related to being reviewed by the peer review body in your organization:
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours
    - greater than 3000 hours

6. In the last calendar year, estimate the TOTAL COST IN DOLLARS ($) you spent being reviewed in an 805 or 821.5 peer review process, including legal fees and all other time and staffing costs.
    - $ 0-50,000
    - $ 50,001-250,000
    - $ 250,001-500,000
    - $ 500,000-1,000,000
    - greater than $1,000,000

7. Please list the reasons of the highest three costs.

8. In the last calendar year, estimate the AMOUNT OF **TIME IN HOURS** spent **IN EACH PHASE** OF (for preparation of, during the process of, and for monitoring/tracking after) an 805 or 821.5 report proceedings. Proceedings are activities conducted by peer review bodies. This includes aggregate time for the involvement of staff, physician reviewers, legal advisers, and administrators, as well as preparation by physicians or midlevel providers who are being reviewed.

	0-250 hours	251-500 hours	501-1000 hours	1000-3000 hours	Greater than 3000 hours
PREPARATION					
DURING THE PROCESS					
MONITORING/TRACKING					

Rate the following question on a scale of 1-5, with 1 being the least likely and 5 being the most likely, in your organization. (note: “political” is defined as being used for purposes other than intended, such as discrimination based on ethnicity or gender, or to remove a competitor)

9. How likely is it that 805 reporting is used for “political” reasons?

10. If you have experienced or are aware of 805 reporting used for reasons other than intended (ensuring patient safety), please list the reasons.

    Rate the following question on a scale of 1-5, with 1 being the least confident and 5 being the most confident.

11. How confident are you that action will be taken by the MBC once an 805 report has been filed?

Rate the following question on a scale of 1-5, with 1 being the least fair and 5 being the most fair.

12. How fair was the peer review process in which you were reviewed?

Rate the following question on a scale of 1-5, with 1 being the least timely manner and 5 being the most timely manner.

13. How timely was the peer review process in which you were reviewed?

14. Were you offered the opportunity for an 809 hearing?
    - Yes
    - No

15. Identify requirements of 809 hearings: (check all that apply)
    - An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the matter.
    - The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer.
    - The right of the licentiate to inspect and copy relevant documents.
    - The parties shall exchange lists of witnesses at the request of either side.
    - Commencing a hearing within 60 days after receipt of the request.
    - None of the above

16. Please include any problems you have experienced with the procedure.

17. Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.
    - No changes necessary
    - Eliminate peer review
    - Create a statewide government entity that conducts peer review
    - Create a statewide government entity that controls credentialing (not just licensing)
    - Hire an independent organization (non-government) to manage and conduct a peer review
    - Other For 'other' recommendations, specify:

Peer Review Survey
Non Physician Organization Staff Survey – "D"

As part of the Medical Board of California Comprehensive Study of the Physician and Surgeon Peer Review Process Project, we are asking that people who serve in various roles in an organization's Peer Review Process complete this survey. The answers to the questions will provide us with information about the individual's understanding, experience, and opinions of the organization's Peer Review Process. Thank you for your willingness to answer these questions.

Please provide the following information related to peer review in your organization. If peer review activities are performed by multiple committees, please respond based on your knowledge of the committee in which you are involved.

Please select your best response without additional consultation or collecting further data. Be assured that your responses will remain confidential. All the data will be in the aggregate and no individual or organization will be identified. If you have any questions about the survey or the report, please contact:

Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
jseago@lumetra.com
415-677-2160 voicemail
415-677-2185 fax

If you would like to review additional information regarding this project, you can refer to the website: www.lumetra.com/mbc.

43. Organization # (If you do not know your #, contact Dr. Seago or your organization contact person)

44. Organization Type
    - Hospital
    - Medical Group
    - Health Plan
    - Professional society

45. Identify your position in the organization related to Peer Review.
    A - Peer Review Body Chair
    B - Physician reviewer for the organization
    C - Physician who has been reviewed
    D - Non-physician organization staff
    E - Attorney who has represented the organization in a peer review
    F - Attorney who has represented a physician being reviewed

4. The major/final Peer Review Body in this organization is called: (check all that apply)
    - Peer review committee
    - Medical Department committee/s
    - Medical Staff Executive committee
    - Credentialing committee
    - Well-being committee
    - Quality committee (Quality Improvement committee)
    - Utilization committee
    - Licensing/Credentialing committee
    - Professional Affairs committee

- Pharmaceutical committee which manages adverse drug effects
- Risk Management committee
- Care Review committee
- Other (please specify)

5. Total number (#) of members
6. Number (#) of committee members who are non-physician staff
7. Number (#) of disciplines represented besides medicine (nursing, medicine, pharmacy, etc)
8. Number (#) of different medical specialties represented(surgery, pediatrics, etc)
9. Number (#) of committee members who are generalists

10. What are the types of specialties that are represented on the committee? (check all that apply)
    - Anesthesiology
    - Emergency Medicine
    - Family Practice
    - IM subspecialty - Pediatric subspecialty
    - Internal Medicine
    - OB/Gynecology
    - Psychiatry
    - Radiology
    - Surgery
    - Pediatrics
    - Other (please specify)

11. Schedule of committee meetings: How often does this peer review body meet?
    - Monthly
    - Quarterly
    - Bi-weekly
    - Bi-annually (every 6 months)

12. Indicate the methods used in recruiting members to the Peer Review Body: (check all that apply)
    - Payment is offered by organization
    - Requirement for affiliation/employment
    - Requirement for hospital privileges
    - Experience in peer review
    - Interest in peer review
    - Willingness to serve
    - Scheduled/rotating obligation
    - Other Indicate 'other' methods:

13. Is committee composition determined by any of the following: (check all that apply)
    - A specific percentage of physician specialists (ex: orthopedists, pediatricians, etc.)
    - A specific percentage of physician generalists (ex: primary care or family practice, etc.)
    - A specific percentage of mid-level providers (ex: nurse practitioners, physician assistants, certified registered, nurse assistants, midwives, etc.)
    - A specific percentage of non-physicians (registered nurses, therapists, social workers, etc.)
    - None of the above
    - Other (please specify)

14. In the last calendar year, how many new members were added to the peer review body?

15. In the last calendar year, how many individuals were approached to serve on a peer review body?

16. If applicable, of those approached, how many refused?

17. Indicate reason(s) for non-participation.
    - N/A
    - Too busy
    - Interferes with practice
    - Do not like to judge colleagues
    - Other (please specify)

18. In the last calendar year, how many unanticipated member changes have occurred in the peer review body?

19. If applicable, indicate the reason(s) for the changes.
    - Term expired
    - Member moved out of the area
    - Member retired
    - Moved practice
    - Dropout
    - If 'other' reasons, specify:

20. Indicate responsibilities of the peer review body: (check all that apply)
    - Quality of care concern (evaluate)
    - Utilization of care (evaluate)
    - Initial screening for patient care issue related to an organizational or systems-problem
    - Initial screening for patient care issue related to a physician's practice
    - Sentinel event
    - A physician's practice pattern
    - Series of complaints/events about physician
    - Secondary or final determination of action, if any, to be taken for a patient care issue related to a physician's practice
    - Tracking or monitoring of a physician's practice issue
    - Submit an 805 report
    - Submit an 821.5 report
    - Convene or oversight of an 809 hearing
    - Other If 'other' responsibilities, specify:

21. In your organization, indicate circumstances or criteria for which an 805 or 821.5 report WOULD BE CONSIDERED: (check all that apply) A: INITIAL MECHANISMS in your organization by which potential 805 or 821.5 issues are identified (an 805 report is a peer review body action taken for medical disciplinary cause or reason; an 821.5 report is action taken related to a physician's disabling mental or physical condition): B: Criteria/circumstances used to determine whether an issue is taken to a SECONDARY or HIGHER LEVEL REVIEW body in your organization:

Reason	A Initial Mechanisms	B Secondary Review
Patient complaint		
Multiple patient complaints		
Provider (mid-level/physician) complaint		
Multiple provider (mid-level/physician) complaints		
Nurse or other hospital employee complaint		
Multiple nurse or other hospital employee complaints		
Health plan complaint		
Multiple health plan complaints		
Quality program screening issue		
Utilization program screening issue		
Peer Review Committee screening issue required for the IPA, Health Plan membership, and/or hospital affiliation		
Risk management committee screening issue		
Provider practice pattern that is not consistent with the general standards of care		
Repeated allegations or errors in the delivery of care		
Potentially gross and flagrant care that endangers patient		
Egregious/sentinel event		
Malpractice case		
Arbitration/Mediation case		
Limitation or restriction of practice		
Required proctoring		
Other If 'other' criteria, specify and state for either scenario A or B above:		

22. Indicate the **position** of the person, committee, or mechanism that determines whether to refer an issue to a secondary or higher review body in the organization: (check all that apply)
    - Chair of initial screening committee
    - A majority vote of the initial screening committee
    - Peer review chair
    - Organization policies & procedures
    - Medical Department Chair
    - A majority vote of the Medical Department members
    - Professional Affairs Committee decision
    - Credentialing Committee decision
    - Risk Management Committee decision
    - Other For 'other,' specify:

23. In your organization, indicate the **criteria** used to determine whether a case is REPORTED (805 or 821.5) to the Medical Board of California (MBC): (check all that apply)
    - Patient complaint
    - Multiple patient complaints

- Provider (mid-level/physician) complaint
- Multiple provider (mid-level/physician) complaints
- Nurse or other hospital employee complaint
- Multiple nurse or other hospital employee complaints
- Health plan complaint
- Multiple health plan complaints
- Quality program screening issue
- Utilization program screening issue
- Peer Review Committee screening issue for the IPA, Health Plan membership, and/or hospital affiliation
- Risk management committee screening issue
- Provider practice pattern that is not consistent with the general standards of care or evidence-based medicine
- Repeated allegations or errors in the delivery of care
- Potentially gross and flagrant care
- Egregious/sentinel event
- Malpractice case
- Arbitration/Mediation case
- Limitation or restriction of practice
- Required proctoring
- Other For 'other' criteria, specify.

24. Indicate the **person, committee, or mechanism** that determines whether an issue (805 or 821.5) is reported to the Medical Board of California (MBC): (check all that apply)
    - Chair of secondary or final determination committee
    - A majority vote of the final review committee
    - Peer review chair
    - Organization policies & procedures
    - Medical Department Chair
    - A majority vote of the Medical Department members
    - Professional Affairs Committee decision
    - Credentialing Committee decision
    - Risk Management Committee decision
    - Other For 'other,' specify.

25. After a reportable event (805 or 821.5), the organization's designated peer review officer must submit a report to the relevant agency within:
    - 1 - 15 days
    - 16 - 30 days
    - 31 - 45 days
    - Other (specify estimate number of days)

26. After the licentiate has satisfied the terms of a disciplinary action, a supplemental report is made to the relevant agency within:
    - 1 - 30 days
    - 31 - 60 days
    - 61 - 90 days
    - Other (specify estimate number of days)

27. After initiating a formal investigation of a potential 821.5 event, the organization's designated peer review officer must submit a report within:
    - 1 - 15 days
    - 16 - 30 days
    - 31 - 45 days
    - Other (specify estimate range of days)

28. Upon receipt of an 821.5 report, the MBC diversion program administrator shall contact the reporting peer review body within:
    - 1 - 60 days
    - 61 - 90 days
    - 91 - 120 days
    - Other (specify estimate range of days)

29. Indicate the criteria used for filing/not filing an 805 report: (check all that apply)
    - When a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason
    - When a peer review body takes an action that terminates or Revokes a licentiate's membership, staff privileges, or employment
    - When a peer review body imposes or a licentiate voluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason
    - After notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason
    - Resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership.
    - The imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days
    - Other For 'other' criteria, specify.

30. Indicate the criteria used for filing an 821.5 report for a physician or surgeon POSING A THREAT TO PATIENT CARE: (check all that apply)
    - Physician or surgeon suffering from a disabling mental condition
    - Physician or surgeon suffering from a disabling physical condition
    - Physician or surgeon suffering from a substance abuse condition
    - Other For 'other' criteria, specify.

18. In the last calendar year, estimate the **TOTAL AMOUNT** of time **IN HOURS** spent (including preparation, meetings, etc.) by the following staff for all actual or potential 805 or 821.5 issues reviewed by the Peer Review Body: organization staff (i.e., managers, committee members, and administrators) physician staff
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours

- greater than 3000 hours

19. In the last calendar year, estimate the AMOUNT OF **TIME IN HOURS** spent **IN EACH PHASE** OF (for preparation of, during the process of, and for monitoring/tracking after) an 805 or 821.5 report proceedings. Proceedings are activities conducted by peer review bodies. This includes aggregate time for the involvement of staff, physician reviewers, legal advisers, and administrators, as well as preparation by physicians or midlevel providers who are being reviewed.

	0-250 hours	251-500 hours	501-1000 hours	1000-3000 hours	Greater than 3000 hours
PREPARATION					
DURING THE PROCESS					
MONITORING/TRACKING					

20. For the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS spent by the organization on 809 hearings:
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours
    - greater than 3000 hours

21. For the last calendar year, estimate the TOTAL COST IN DOLLARS ($) spent by the organization on 809 hearings:
    - $ 0-50,000
    - $ 50,001-250,000
    - $ 250,001-500,000
    - $ 500,000-1,000,000
    - greater than $1,000,000

22. For the typical calendar year, how has the amount spent by the organization on 809 hearings varied from the last calendar year?
    - Less than the last calendar year
    - More than the last calendar year
    - Same amount as the last calendar year

Rate the following question on a scale of 1-5, with 1 being the least likely and 5 being the most likely, in your organization. (note: “political” is defined as being used for purposes other than intended, such as discrimination based on ethnicity or gender, or to remove a competitor)

23. How likely is it that 805 reporting is used for “political” reasons?

24. If you have experienced or are aware of 805 reporting used for reasons other than intended (ensuring patient safety), please list the reasons.

Rate the following question on a scale of 1-5, with 1 being the least confident and 5 being the most confident.

25. How confident are you that action will be taken by the MBC once an 805 report has been filed?

Rate the following question on a scale of 1-5, with 1 being the least difficult and 5 being the most difficult.

26. What is the level of difficulty (eg. user-friendliness, clear documentation) for using the MBC's current 805 reporting forms?

27. List your recommendations for changes to the 805 reporting forms to make them more user-friendly and clear:

28. Have you been involved in an 809 hearing?
    - Yes
    - No

Rate the following question on a scale of 1-5, with 1 being the least efficient and 5 being the most efficient.

29. How efficient (in relation to timeliness and duration) was the 809 hearing process?

Rate the following question on a scale of 1-5, with 1 being the least effective and 5 being the most effective.

30. How effective (ensuring individual rights and that the process was followed) was the 809 hearing process?

31. Identify requirements of 809 hearings: (check all that apply)
    - An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the matter.
    - The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer.
    - The right of the licentiate to inspect and copy relevant documents.
    - The parties shall exchange lists of witnesses at the request of either side.
    - Commencing a hearing within 60 days after receipt of the request.
    - None of the above
    - Other (please specify)

32. Please include any problems you have experienced with the procedure.

33. Indicate all obstacles applicable to each type of reporting (805 and 821.5) that you have experienced or would predict: (check all that apply)

Obstacle	805 reporting	821.5 reporting
N/A		
Reluctance to take action against friend/colleague		
Fear of being sued for restricting trade of a competitor		
Reluctance to take action because of potential for retribution		
Organization uses “internal punishment” (resignation, practice restriction) to reduce reporting		
Organization encourages an “administrative resolution” (MD agrees to resign in exchange for the organization not filing a report)		
No obstacles		
Other For 'other' obstacles, specify and indicate type of reporting (805 or 821.5):		

47. Indicate your recommendations to avoid the above obstacles: (check all that apply)
    - Peer review to be completed by physicians outside the geographic area
    - Independent body conducts the peer review (independent of the organization)
    - Nonlicensing body conducts the peer review (independent of state agencies)
    - No changes necessary
    - Other For 'other' recommendations, specify.

48. Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.
    - No changes necessary
    - Eliminate peer review
    - Create a statewide government entity that conducts peer review
    - Create a statewide government entity that controls credentialing (not just licensing)
    - Hire an independent organization (non-government) to manage and conduct a peer review
    - Other For 'other' recommendations, specify:

49. In your organization, if repeated allegations are raised against a particular provider, would the organization allow this provider to maintain their practice privileges?
    - Yes
    - No

50. Please identify potential reasons the organization would allow a provider with repeated allegations raised against them to maintain their practice privileges? (check all that apply)
    - N/A
    - The provider brings in a large amount of revenue
    - The provider admits many patients
    - The provider is the only specialist of a specific type in the geographic area
    - The provider has been with the organization for many years
    - The organization cannot find a replacement
    - The organization would not allow such a provider to practice
    - Other If 'other' reasons, specify.

Peer Review Survey
Attorney Representing Organization Survey – "E"

As part of the Medical Board of California Comprehensive Study of the Physician and Surgeon Peer Review Process Project, we are asking that people who serve in various roles in an organization's Peer Review Process complete this survey. The answers to the questions will provide us with information about the individual's understanding, experience, and opinions of the organization's Peer Review Process. Thank you for your willingness to answer these questions.

Please provide the following information related to peer review in your organization. If peer review activities are performed by multiple committees, please respond based on your knowledge of the committee in which you are involved.

Please select your best response without additional consultation or collecting further data. Be assured that your responses will remain confidential. All the data will be in the aggregate and no individual or organization will be identified. If you have any questions about the survey or the report, please contact:

Jean Ann Seago, PhD, RN
Project Consultant
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jseago@lumetra.com
415-677-2160 voicemail
415-677-2185 fax

If you would like to review additional information regarding this project, you can refer to the website: www.lumetra.com/mbc.

46. Organization # (If you do not know your #, contact Dr. Seago or your organization contact person)

47. Organization Type
    - Hospital
    - Medical Group
    - Health Plan
    - Professional society

48. Identify your position in the organization related to Peer Review.
    A - Peer Review Body Chair
    B - Physician reviewer for the organization
    C - Physician who has been reviewed
    D - Non-physician organization staff
    E - Attorney who has represented the organization in a peer review
    F - Attorney who has represented a physician being reviewed

4. Indicate the criteria used for filing/not filing an 805 report: (check all that apply)
    - when a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason.
    - when a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges, or employment.
    - when a peer review body imposes or a licentiate voluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason.
    - after notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason

- resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership.
- the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.
- Other For 'other' criteria, specify.

5. In the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS you spent (including preparation, meetings, etc.) on behalf of the organization for all actual or potential 805 or 821.5 issues reviewed by the Peer Review Body:
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours
    - greater than 3000 hours

6. In the last calendar year, estimate the AMOUNT OF **TIME IN HOURS** spent **IN EACH PHASE** OF (for preparation of, during the process of, and for monitoring/tracking after) an 805 or 821.5 report proceedings. Proceedings are activities conducted by peer review bodies. This includes aggregate time for the involvement of staff, physician reviewers, legal advisers, and administrators, as well as preparation by physicians or midlevel providers who are being reviewed.

	0-250 hours	251-500 hours	501-1000 hours	1000-3000 hours	Greater than 3000 hours
PREPARATION					
DURING THE PROCESS					
MONITORING/TRACKING					

7. For the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS you spent on the 809 hearing(s):
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours
    - greater than 3000 hours

Rate the following question on a scale of 1-5, with 1 being the least likely and 5 being the most likely, in your organization. (note: “political” is defined as being used for purposes other than intended, such as discrimination based on ethnicity or gender, or to remove a competitor)

8. How likely is it that 805 reporting is used for “political” reasons?

9. If you have experienced or are aware of 805 reporting used for reasons other than intended (ensuring patient safety), please list the reasons.

Rate the following question on a scale of 1-5, with 1 being the least confident and 5 being the most confident.

10. How confident are you that action will be taken by the MBC once an 805 report has been filed?

11. Have you represented a client(s) in an 809 hearing?
    - Yes
    - No

Rate the following question on a scale of 1-5, with 1 being the least efficient and 5 being the most efficient.

12. How efficient (in relation to timeliness and duration) was the 809 hearing process?

Rate the following question on a scale of 1-5, with 1 being the least effective and 5 being the most effective.

13. How effective (ensuring individual rights and that the process was followed) was the 809 hearing process?

14. Identify requirements of 809 hearings: (check all that apply)
    - An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the matter.
    - The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer.
    - The right of the licentiate to inspect and copy relevant documents.
    - The parties shall exchange lists of witnesses at the request of either side.
    - Commencing a hearing within 60 days after receipt of the request.
    - None of the above

15. Please include any problems you have experienced with the procedure.

16. Indicate all obstacles applicable to each type of reporting (805 and 821.5) that you have experienced or would predict: (check all that apply)

Obstacle	805 reporting	821.5 reporting
N/A		
Reluctance to take action against friend/colleague		
Fear of being sued for restricting trade of a competitor		
Reluctance to take action because of potential for retribution		
Organization uses “internal punishment” (resignation, practice restriction) to reduce reporting		
Organization encourages an “administrative resolution” (MD agrees to resign in exchange for the organization not filing a report)		
No obstacles		
Other For 'other' obstacles, specify and indicate type of reporting (805 or 821.5):		

17. Indicate your recommendations to avoid the above obstacles: (check all that apply)
    - Peer review to be completed by physicians outside the geographic area
    - Independent body conducts the peer review (independent of the organization)
    - Nonlicensing body conducts the peer review (independent of state agencies)
    - No changes necessary
    - Other For 'other' recommendations, specify.

18. Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.

- No changes necessary
- Eliminate peer review
- Create a statewide government entity that conducts peer review
- Create a statewide government entity that controls credentialing (not just licensing)
- Hire an independent organization (non-government) to manage and conduct a peer review
- Other For 'other' recommendations, specify:

Peer Review Survey
Attorney Represented Physician Survey – "F"

As part of the Medical Board of California Comprehensive Study of the Physician and Surgeon Peer Review Process Project, we are asking that people who serve in various roles in an organization's Peer Review Process complete this survey. The answers to the questions will provide us with information about the individual's understanding, experience, and opinions of the organization's Peer Review Process. Thank you for your willingness to answer these questions.

Please provide the following information related to peer review in your organization. If peer review activities are performed by multiple committees, please respond based on your knowledge of the committee in which you are involved.

Please select your best response without additional consultation or collecting further data. Be assured that your responses will remain confidential. All the data will be in the aggregate and no individual or organization will be identified. If you have any questions about the survey or the report, please contact:

Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
jseago@lumetra.com
415-677-2160 voicemail
415-677-2185 fax

If you would like to review additional information regarding this project, you can refer to the website: www.lumetra.com/mbc.

49. Organization # (If you do not know your #, contact Dr. Seago or your organization contact person)

50. Organization Type
    - Hospital
    - Medical Group
    - Health Plan
    - Professional society

51. Identify your position in the organization related to Peer Review.
    A - Peer Review Body Chair
    B - Physician reviewer for the organization
    C - Physician who has been reviewed
    D - Non-physician organization staff
    E - Attorney who has represented the organization in a peer review
    F - Attorney who has represented a physician being reviewed

4. Indicate the criteria used for filing/not filing an 805 report: (check all that apply)
    - when a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason.
    - when a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges, or employment.
    - when a peer review body imposes or a licentiate voluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason.
    - after notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason

- resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership.
- the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.
- Other For 'other' criteria, specify.

5. In the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS you spent (including preparation, meetings, etc.) in behalf of your clients for all actual or potential 805 or 821.5 issues reviewed by a Peer Review Body:
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours
    - greater than 3000 hours

6. In the last calendar year, estimate the AMOUNT OF TIME IN HOURS you spent IN EACH PHASE OF (for preparation of, during the process of, and for monitoring/tracking after) an 805 or 821.5 report proceedings. Proceedings are activities conducted by peer review bodies. This includes aggregate time for the involvement of staff, physician reviewers, legal advisers, and administrators, as well as preparation by physicians or midlevel providers who are being reviewed.

	0-250 hours	251-500 hours	501-1000 hours	1000-3000 hours	Greater than 3000 hours
PREPARATION					
DURING THE PROCESS					
MONITORING/TRACKING					

7. For the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS you spent on 809 hearings:
    - 0-250 hours
    - 251-500 hours
    - 501-1000 hours
    - 1000-3000 hours
    - greater than 3000 hours

Rate the following question on a scale of 1-5, with 1 being the least likely and 5 being the most likely, in your organization. (note: “political” is defined as being used for purposes other than intended, such as discrimination based on ethnicity or gender, or to remove a competitor)

8. How likely is it that 805 reporting is used for “political” reasons?

9. If you have experienced or are aware of 805 reporting used for reasons other than intended (ensuring patient safety), please list the reasons.

10. Have you represented a client(s) in an 809 hearing?
    - Yes
    - No

    Rate the following question on a scale of 1-5, with 1 being the least efficient and 5 being the most efficient.

11. How efficient (in relation to timeliness and duration) was the 809 hearing process?

Rate the following question on a scale of 1-5, with 1 being the least effective and 5 being the most effective.

12. How effective (ensuring individual rights and that the process was followed) was the 809 hearing process?

13. Identify requirements of 809 hearings: (check all that apply)
    - An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the matter.
    - The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer.
    - The right of the licentiate to inspect and copy relevant documents.
    - The parties shall exchange lists of witnesses at the request of either side.
    - Commencing a hearing within 60 days after receipt of the request.
    - None of the above

14. Please include any problems you have experienced with the procedure.

15. Indicate all obstacles applicable to each type of reporting (805 and 821.5) that you have experienced or would predict: (check all that apply)

Obstacle	805 reporting	821.5 reporting
N/A		
Reluctance to take action against friend/colleague		
Fear of being sued for restricting trade of a competitor		
Reluctance to take action because of potential for retribution		
Organization uses “internal punishment” (resignation, practice restriction) to reduce reporting		
Organization encourages an “administrative resolution” (MD agrees to resign in exchange for the organization not filing a report)		
No obstacles		
Other For 'other' obstacles, specify and indicate type of reporting (805 or 821.5):		

16. Indicate your recommendations to avoid the above obstacles: (check all that apply)
    - Peer review to be completed by physicians outside the geographic area
    - Independent body conducts the peer review (independent of the organization)
    - Nonlicensing body conducts the peer review (independent of state agencies)
    - No changes necessary
    - Other For 'other' recommendations, specify.

17. Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.
    - No changes necessary
    - Eliminate peer review
    - Create a statewide government entity that conducts peer review
    - Create a statewide government entity that controls credentialing (not just licensing)
    - Hire an independent organization (non-government) to manage and conduct a peer review
    - Other For 'other' recommendations, specify:

Questions for MBC staff members

1. Describe the historical perspective of the PR process.
2. What do you see as the trends in the reporting process?
3. What is your understanding of when an 805/821.5 report should be filed?

   For the purposes of this section, 809.1. (a) the "final proposed action" shall be the final decision or recommendation of the peer review body after informal investigatory activity or prehearing meetings, if any.
4. What is your understanding of the sequence of events leading up to 805/821.5 report?
5. What are some reasons for not filing an 805/821.5 report?
6. How confident are you that action will be taken once an 805/821.5 report has been filed?
7. In some of the organizations' bylaws there are timelines for reporting and the hearing that mirror the n 805/821.5 and 809 timelines. They are typically not explicitly related to the 805/821.5 and 809 laws. Does that make a difference?
8. In 805. (a) 1. A. and B. [(A) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare Program as an ambulatory surgical center.

   (B) A health care service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer the contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.]. We found a list of licensed health plans on

from the Department of Managed Health Care website. We have found a list of licensed specialty and primary clinics on the OSHPD website and related to Medi-Cal. We used a more comprehensive list of medical groups and health plans to pull our sample. However, it is not clear what "licensed" or "registered" means. Can you explain?

9. Are the standard reporting forms completed correctly and completely?
10. Do the standard forms need to be changes? How?
11. Is there a need for other standard forms for reporting from the peer review bodies?
12. Is there a need to further standardize the language in the legislation related to 805/821.5 reporting?
13. What obstacles do you see to 805/821.5 peer review reporting?
14. What would you recommend to reduce obstacles?
15. What are the most common reasons given to the board for not filing an 805/821.5 report?
16. Is it your understanding that an 809 hearing is required or at least offered before every n 805/821.5 report is filed?
17. Is the 809 hearing process efficient?
18. Is the 809 hearing process effective?
19. How much time do you think is spent on 809 hearings?
20. What does think is the cost of 809 hearings to organizations?
21. Do you think hearings comply with 809.2 a-h?
22. Do you believe that 805/821.5 reporting is used for political reasons? (ethnicity/ gender/language discrimination; remove a competitor, etc)

Focus Group Questions

Broader questions

1. Given that patient safety is the goal, are there adequate processes in place to insure safe medical care for the citizens of California?
2. If not, what would you recommend to improve the processes to insure safe medical care? Please describe your specific ideas.

Specific Questions:

On a rating scale of 1-5 with 1 being the least/worst and 5 being the most/best:

1. How would you rate the effectiveness of the peer review process in California?
    a. The effectiveness of 805 reporting
    b. The effectiveness of the 809 hearing process?
2. How would you rate the efficiency of the peer review process in California?
    a. The efficiency of 805 reporting?
    b. The efficiency of the 809 hearing process?
3. How would you rate the fairness/equitability of the peer review process in California?
    a. The fairness/equitability of 805 reporting?
    b. The fairness/equitability of the 809 hearing process?
4. Would you say there are barriers to member selection for peer review? (Political, Economic, Legal, Financial, Time, Cultural) Is there resistance to becoming a member?

5. Do you have a good understanding on how to complete 805 documents?
6. Compare the peer review process in healthcare as a measure of safety with similar processes in other industries.
    a. Function and outcome
    b. Does medical peer review impact patient safety?
7. Are there differences in process and equity among organization (hospitals, health plans, medical groups) that are required to file 805 reports to MBC?
8. Do you see patterns in types of peer review cases about whether specific physician specialties are targeted?
9. Please describe specific ideas to improve the peer review process (what, who, how—new ways to do peer review, eliminate peer review, replace peer review with something else, redirect the notion of review toward systems rather than individuals)

Lumetra
Brighter insights. Better healthcare.

Appendix III: Hospital Related Documents

- Correspondence from hospitals in response to Lumetra request for documents
- Example of Medical Staff Bylaws Template

[redacted]

October 22, 2007

[redacted]

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections.

[redacted]

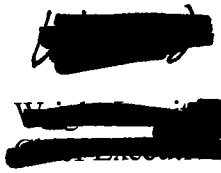
Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the distinct possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,



[redacted]

October 22, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an

[redacted]

unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.
- Institutional forms and templates used in review activities.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]

[redacted]

OF COUNSEL
[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of

medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

A. Medical staff/peer review provisions of the governing body bylaws
B. Medical Staff bylaws
C. Medical Staff rules and regulations
D. Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
E. Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
F. Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:
    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
    2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
    3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, since the type of situations reported were not logged for this purpose,

it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

[redacted]

[redacted]

[redacted]
Enclosures

[redacted]

[redacted]

October 30, 2007

Ms. Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007, requested certain documents from [redacted] in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes a study of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007, California hospitals participated in a conference call with you in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents must be produced - other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all cases is an insurmountable burden, no matter what time frame is involved. Because Lumetra has not been able to narrow or tailor its request to assist California hospitals to respond, we are left with no option but to interpret the request as best we can to produce what appears to be a reasonable response to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the conference call. Records relating to mental health care under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not override any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not

[redacted]

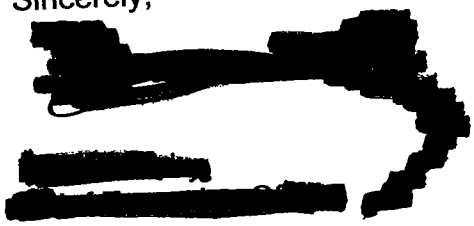
insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provides some level of protection with respect to your maintenance of these records, it may not adequately guard against others' access to these records - especially through the exercise of governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws
- Medical staff bylaws
- Medical staff rules and regulations
- Peer review policy
- Section 805 reports filed between September 2001 and September 2007

We look forward to cooperating with you as best we can on your project.

Sincerely,



[redacted]

[redacted]

[redacted]

November 14, 2007

Jean Ann Seago, Ph.D., RN.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

[redacted]

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced — other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study While we appreciate that the legislation provided some level of protection with

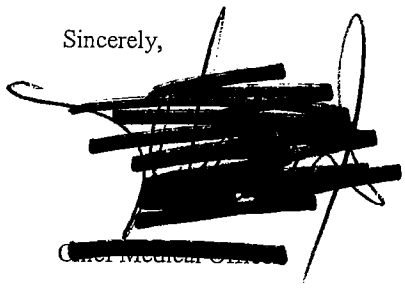
respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records — whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,



Chief Medical Officer

[redacted]

[redacted]

November 7, 2007

Jean Ann Seago, PhD, RN
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

CONFIDENTIAL

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has

ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

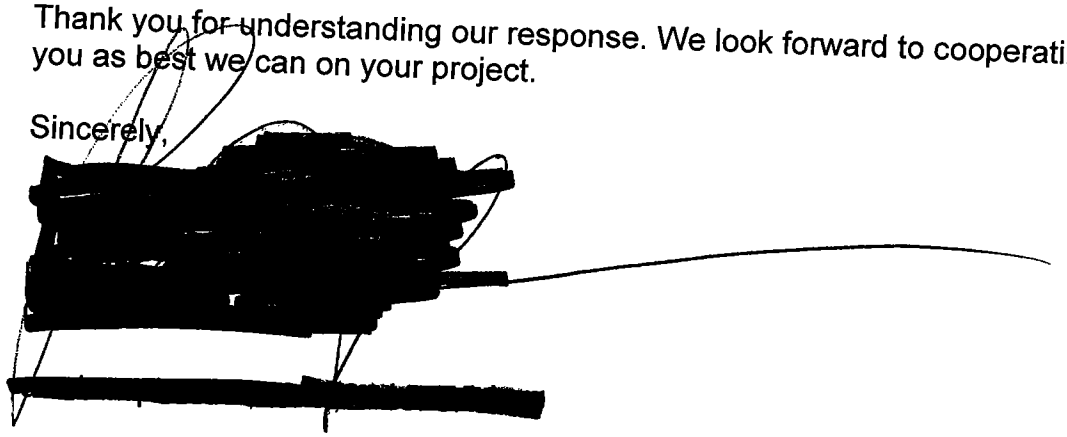
Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Medical Staff bylaws and rules and regulations
- Peer review policies and procedures
- Peer review profiles
- Section 805 reports filed between September 2001 and September 2007 (There were no reports submitted to the Medical Board of California from Chinese Hospital.)

In no way shall the documentation submitted to Lumetra from [redacted] be duplicated, copied, or re-submitted to any other organizations. All documentation submitted to Lumetra must be keep confidential and returned to [redacted] no later than March 3, 2008.

Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,



[redacted]

Via Overnight Mail
October 23, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

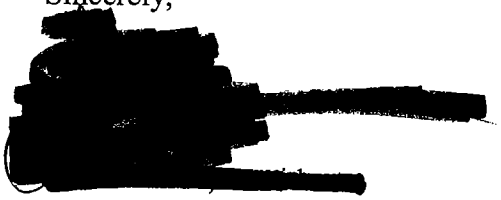
[redacted]

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,



cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

October 29, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Via Overnight Mail

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

[redacted]

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws
- Professional medical staff bylaws
- Professional medical staff rules and regulations
- Peer review policies and procedures
- Section 805 reports filed between September 2001 and September 2007

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

c: [redacted]

Enclosures:

- Hospital Community Board Bylaws
- Medical Staff Bylaws
- Medical Staff Rules and Regulations
- Peer Review Policies and Procedures
- Section 805 Reports, September 2001 through September 2007

[redacted]

[redacted]

Via Overnight Mail
November 2, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007. Please note there were no Section 805 reports required to be filed at [redacted] during this time period.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

Via Overnight Mail

11-4-07

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

[redacted]

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted]. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosures
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted] [redacted] [redacted]

October 16, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

[redacted] [redacted]

Anne Seago, Ph.D., R.N.
Lumetra

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

[redacted]

[redacted]

Via Overnight Mail
November 26, 2007

Jean Ann Seago, PhD, RN
Lumetra
One Sansome Street
Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance

ese records, it does not appear to adequately guard against others' access these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

[redacted] has not filed any 805 reports during the timeframe outlined above.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures

[redacted]

[redacted]

[redacted]

Via Overnight Mail
Novemeber 1, 2007

[redacted]

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

[redacted]

//

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

CONFIDENTIAL

October 30, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Peer Review Study of Behalf of the Medical Board of California

Dear Dr. Seago:

As the Director of Quality and Risk Management for th[redacted], which includes [redacted] ("the Hospital"), I have been designated as the Hospital's contact person for purposes of responding to Lumetra's letter dated September 17, 2007, requesting certain data for the study entitled "Comprehensive Description of the Peer Review Process in California." This letter and the accompanying documents will constitute the Hospital's response.

It is important to note, preliminarily, that we participated in your telephone conference call on October 5, 2007, which was facilitated by the California Hospital Association for the purpose of giving you an opportunity to clarify the nature and scope of this study and answer questions about it. The call was convened because Lumetra's requests and instructions, as presented in the September 17 letter, were confusing and, taken literally, called for hospitals to perform extraordinarily burdensome and time consuming tasks. There were also serious concerns about the disclosure of confidential patient and peer review information, and whether the assurances of appropriateness and protection provided by Lumetra and the Medical Board are entirely reliable under the law. Based on your comments, we understand that Lumetra's fundamental goal is to explore the processes used by hospitals to determine whether or not to file reports with the Medical Board under Sections 805 and 821.5 of the Business and Professions Code, and that you are not interested in extraneous information, despite the broadly worded "List of Required Documents" that was attached to the September 17 letter. We are responding accordingly, in good faith and after having devoted considerable resources to this project.

[redacted]

1. **Charters, Bylaws, and Policies and Procedures**

We do not understand the request at it relates to "charters," as the Hospital has no instruments designated as such that relate to the subject matter of this study. However, we offer the following instruments, which we believe will meet Lumetra's needs:

- Governing Board Bylaws
- Medical Staff Bylaws
- Medical Staff Rules and Regulations
- Medical Staff Peer Review Policy and Procedure

Note: As you will see, these instruments do not describe the circumstances under which reports are made to the Medical Board, because the Hospital's reporting responsibilities are determined by law, as described authoritatively and extensively in Sections 805 and 821.5 of the Business and Professions Code. These laws require reports regarding *physicians*, not *"cases"* or *"patients"* as suggested by Lumetra's requests for information.

2. **Minutes and Agendas for the Last Five Years**

We have searched the minutes and agendas for the Medical Executive Committee, only, because, based on the language of the reporting statutes and the definition of "Investigation" in the Medical Staff Bylaws, potentially reportable events can occur only as a result of the activities of that Committee.

Our search revealed four matters of potential relevance to Lumetra's study as explained above. In lieu of disclosing the full names of the physicians involved, we will refer to them by the first letter of their respective surnames. Redacted copies of Medical Executive Committee minutes and related documents are enclosed, showing the excerpts for these matters, the nature of the issues, and whether reports were made as required by law. Please note:

- [redacted] was obligated to attend an anger management course. No action was taken that adversely affected his clinical privileges, so no report was required by law, and no report was made.

- Some of [redacted]'s cases were reviewed and criticized by an outside expert in a preliminary assessment of vascular surgery services at the Hospital. The Medical Executive Committee determined that the assessment was substantially flawed, and that it would be inappropriate to draw any unfavorable conclusions from it. [redacted] then decided voluntarily to relinquish his [redacted] for reasons relating to the management of his own practice. No peer review investigation was pending or

imminent, nor was any adverse action pending or imminent, regarding [redacted] privileges at the time of the relinquishment. No report was required by law, and no report was made.

- [redacted] had some behavioral problems and was required to sign an agreement that he would comply with the Hospital's policies and practices regarding the administration of drugs to patients in the Emergency Department. He was also evaluated by a psychiatrist, who did not find him to be impaired. However, ongoing behavioral problems were brought to the attention of the Medical Group that employed him, and he subsequently resigned from the Group. Because the Group had an exclusive agreement to provide physician services Emergency Department, [redacted]'s resignation was viewed as tantamount to a resignation from the Medical Staff while under investigation for medical disciplinary cause or reason. Accordingly, the Hospital reported his resignation to the Medical Board under Section 805 of the Business and Professions Code.

- [redacted]s clinical privileges were suspended for a cumulative total of more than thirty days in a twelve-month period, as a result of medical records delinquencies, some of which involved omissions that could adversely affect patient care. As a result, a report was filed with the Medical Board under Section 805 of the Business and Professions Code.

3. **Peer Review Reporting Forms**

The Peer Review Reporting Forms that are used by the Hospital to comply with Sections 805 and 821.5 of the Business and Professions Code are those published on the Medical Board's website for those purposes.

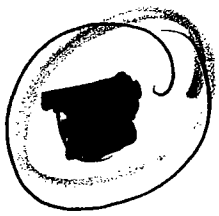
We trust this will meet Lumetra's needs, as described in its request and explained by you in the October 5 conference call. If Lumetra would like to review additional Medical Staff documents or specific patient records, please write or call me to make appropriate and mutually acceptable arrangements. I can be reached at [redacted] e-mail: [redacted].

Very truly yours,

[redacted]

Enclosures
Governing Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Medical Staff Peer Review Policy and Procedure
Medical Executive Minutes and 805 Reports

[redacted]



[redacted]

Via Overnight Mail
November 13, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

November 1, 2007

[redacted]

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Per your recent phone call to this facility, here are the documents you requested we produce in connection with a study Lumetra has agreed to perform on behalf of the Sate of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

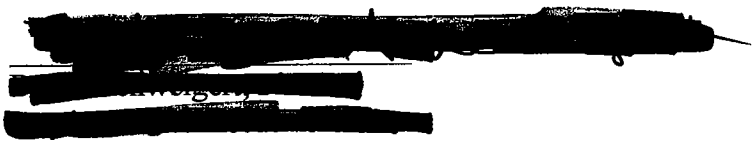
[redacted]

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute::

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,



cc: [redacted]

Enclosure
Hospital Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures – *Please see the General Rules Section of the Bylaws Manual*
Section 805 Reports, September 2001 through September 2007

[redacted]

[redacted]

November 5, 2007

Lumetra
Jean Ann Seago, PhD, RN
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007, requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the 'peer review process" and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process" or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six-year period. (During the call, one participant noted that her facility had reviewed 8,100 medical records during that period!). Producing all of these records, and/or the documents and minutes of all the departments and committees that conducted reviews of the care rendered in all of these cases is an unreasonable, unfunded burden, no matter what timeframe is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are significant legal impediments to responding, some of which were also discussed during the call. While Section 805.2 limits access to the information disclosed to you, it does not exonerate the hospital from liability under other legal principles for making the disclosure. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Federal and state laws and regulations severely restrict hospitals from disclosing individually identifiable medical information. While we appreciate that Section 805.2 provides some level of protection after you receive these records, it does not address the legal obligations of the hospitals not to disclose such information.

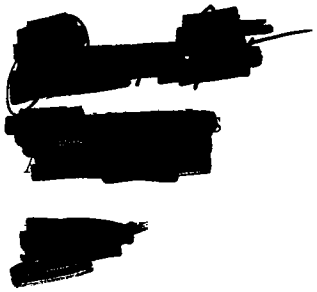
[redacted]

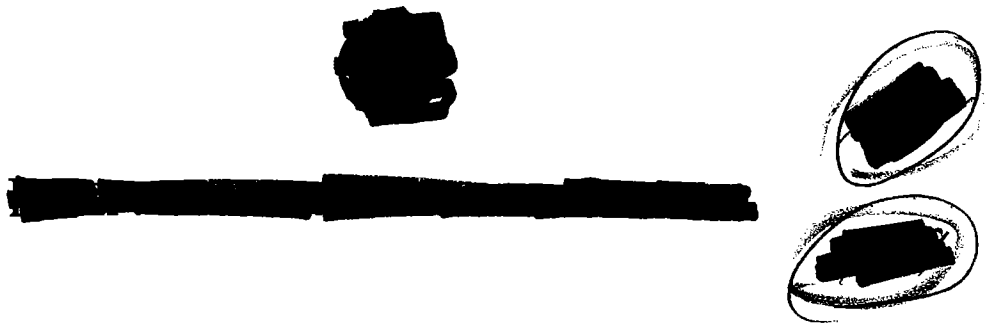
Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws
- Medical Staff bylaws
- Medical Staff rules and regulations
- Peer Review policies
- Section 805 reports filed between September 2001 and September 2007

Thank you for your understanding. We look forward to cooperating with you as best we can on your project.

Sincerely,





October 25, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Lumetra's Request for Documents

Dear Dr. Seago:

Enclosed are the documents that [redacted] believes are responsive to Lumetra's September 17, 2007 request. Please note, however, that [redacted] still finds Lumetra's request for "peer review" documents unclear. Neither the applicable statute nor Lumetra's letter defines many key terms and, in fact, in the letter Lumetra seems to misunderstand what is reported under California Business and Professions Code sections 805 and 821.5. Unless and until Lumetra narrows or clarifies its request to guide our response, we can only interpret the request as best we can to produce documents reasonably responsive to the expressly authorized scope and purpose of the study.

We also have significant concern about Lumetra's request for five years worth of peer review minutes. Due to the legal protections covering peer review, we have never copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, and other peer review documents and sent them offsite. The only exception has been when the Medical Board has subpoenaed information about an identified practitioner that the Medical Board is investigating. To make such copies and send them offsite to a non-governmental agency not only requires a significant amount of resources (and will take much longer than the November 5 deadline to gather and de-identify), it also greatly increases the risk that such copies will be disseminated – intentionally or unintentionally – to third parties not involved in Lumetra's study. Such a breach in confidentiality would undermine the integrity of the peer review process. Although we recognize that the legislation provides some level of protection with respect to your maintenance of these records, it does not appear to guard adequately against others' access.

We understand that on October 5, 2007, you participated in a conference call with a number of hospital representatives and stated that Lumetra does not intend to provide any additional written clarification of its request or the terms it uses in the letter. We also understand that during the call, you instructed the hospitals to provide that information which each hospital believes to be responsive. Therefore, [redacted] is providing the following:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Sample occurrence reporting form.
- Section 805 reports filed between September 2001 and September 2007.
- Section 821.5 reports filed between September 2001 and September 2007. *(None.)*

[redacted]

Letter to Jean Ann Seago, Ph.D., R.N.
Lumetra
[redacted]

We note that the statute authorizing the study requires hospitals to provide raw data, and does not require hospitals to synthesize information into a table. Therefore, we have not entered data into Table 2 of your letter (in large part due to the table's lack of clarity). Your letter also asks [redacted] to explain how it "decides" whether or not to report a "case" to the Medical Board pursuant to Section 805 or Section 821.5. As you may know, "cases" are not reported to the Medical Board; rather, Section 805 requires hospitals to report a licentiate who is subject to a defined set of restrictions (often called "corrective actions"), and Section 821.5 requires hospitals to report formal investigations into whether a physician may be suffering from a disabling mental or physical condition that poses a threat to patient care. When [redacted] formally investigates, restricts, or denies membership or privileges to a licentiate, it evaluates whether that action constitutes a reportable event under either statute. If the action does constitute such an event, then [redacted] files the appropriate report. If the action does not, the hospital does not file a report because a report is not required.

[redacted] has reviewed the corrective actions, including the recommendation to deny membership and/or privileges, which it has taken against licentiates since September 2001. [redacted] has filed Section 805 reports for every action that was reportable, as defined in the statute. The hospital also has reviewed whether any of its formal investigations would be 821.5 reportable. The hospital has filed 821.5 reports for all relevant investigations. Therefore, the hospital does not have any information to disclose about unreported actions.

Finally, please note that although we appreciate Lumetra's rescission of the original October 8, 2007 deadline, its unwillingness to extend the deadline for response beyond November 5, 2007, is inconsistent with both the letter and the spirit of Section 805.2(d). As you know, that section requires the hospital to respond within a mutually agreeable deadline. [redacted] does not agree to November 5, 2007, as the deadline.

If Lumetra is interested in visiting [redacted] to learn more about our peer review process, including to review other documents and records involved in that process, please contact me for an appointment. If you have any questions about [redacted] submission, please do not hesitate to contact me. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]

[redacted]

[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of

medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

A. Medical staff/peer review provisions of the governing body bylaws
B. Medical Staff bylaws
C. Medical Staff rules and regulations
D. Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
E. Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
F. Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:
    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
    2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
    3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, since the type of situations reported were not logged for this purpose,

[redacted]

it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

[redacted]

[redacted]
Enclosures

[redacted]

October 25, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

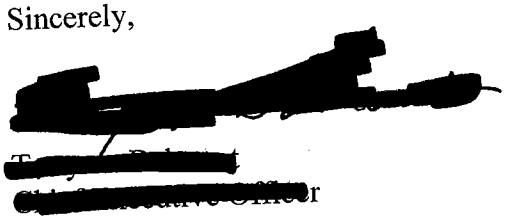
Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing Body Bylaws
- Professional Medical Staff Bylaws
- Professional Medical Staff Rules and Regulations
- Peer Review Policies and Procedures
- Section 805 reports filed between September 2001 and September 2007

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,



[redacted]

cc: [redacted]

Enclosure

- Governing Body Bylaws
- Professional Medical Staff Bylaws
- Professional Medical Staff Rules and Regulations
- Peer Review Policies and Procedures
- Section 805 reports filed between September 2001 and September 2007

[redacted]

[redacted]

November 5, 2007

Certified Mail

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Request for Peer Review Information/ [redacted]
Peer Review Study Authorized by Business and Professions Code, Section 805.2

Dear Dr. Seago:

This responds to your letter dated September 17, 2007, in which you state that [redacted] has been selected to participate in a study of peer review as authorized by Business and Professions Code, Section 805.2.

In your letter you asked for copies [redacted] peer review documents. In response to that portion of the letter, I am enclosing copies of the following:

1. Rules and Regulations of the Governing Board of [redacted];
2. Medical Staff Bylaws of [redacted];
3. [redacted] Medical Staff Rules and Regulations;
4. [redacted]r Policy and Procedure / Performance Improvement Program Plan;
5. [redacted]r Policy and Procedure/ Guidelines for Medical Staff Peer Review Process;
6. Peer Review Form- Confidential;
7. Chair/Vice Chair Peer Review Form-Confidential; and

[redacted]

[redacted]

8. [redacted] Policy and Procedure/ Physician Code of Conduct.

If you have any questions about these documents, you may contact [redacted].

In the letter you also asked for certain information related to "peer reviewed cases" for the period September 2002 through September 2007. In a phone conference on October 5, 2007, facilitated by the California Hospital Association, you clarified that such cases are to include situations where reports were made to the Medical Board of California pursuant to Section 805 or 821.5 of the Business and Professions Code, or were such reports were considered.

In response to that part of the letter, please be advised that the [redacted] and its Medical Staff report actions to the Medical Board as defined in the above-referenced statutes. During the period in question, [redacted] and its Medical Staff reported one matter to the Medical Board. A copy of the Health Facility Reporting Form relating to that matter is enclosed

Aside from that matter, during the time in question, [redacted] had no situations in which a report to the Medical Board was either made or contemplated.

If you would like to discuss the question of "peer review cases" you may contact me.

Very truly yours,

[redacted]

[redacted]

Enclosures

cc: [redacted]

[redacted]

[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of

medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

A. Medical staff/peer review provisions of the governing body bylaws
B. Medical Staff bylaws
C. Medical Staff rules and regulations
D. Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
E. Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
F. Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:
    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
    2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
    3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, since the type of situations reported were not logged for this purpose,

it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

[redacted]

[redacted]

Enclosures

[redacted]

[redacted]

[redacted]

November 4, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant

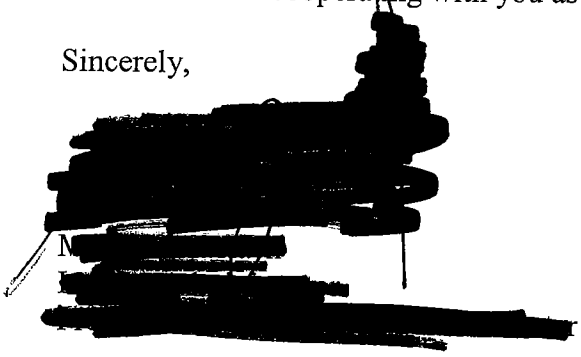
possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

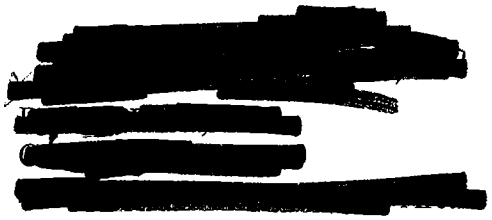
As you know, we requested a deadline extension to November 30, 2007. Even though the deadline is supposed to be based on a mutually agreeable date, this request was not granted. Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,





[redacted]

November 5, 2007

Certified Mail

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Request for Peer Review Information/ [redacted]
Peer Review Study Authorized by Business and Professions Code, Section 805.2

Dear Dr. Seago:

This responds to your letter dated September 17, 2007, in which you state that [redacted]") has been selected to participate in a study of peer review as authorized by Business and Professions Code, Section 805.2.

In your letter you asked for copies of [redacted]s peer review documents. In response to that portion of the letter, I am enclosing copies of the following:

1. Bylaws of the Medical Staff;
2. General Rules and Regulations of the Medical Staff;
3. Medical Staff Policy and Procedure on "Peer Review;"
4. Medical Staff Policy and Procedure on "Disruptive Practitioners."

If you have any questions about these documents, you may contact [redacted]

In the letter you also asked for certain information related to "peer reviewed cases" for the period September 2002 through September 2007. In a phone conference

[redacted]

on October 5, 2007, facilitated by the California Hospital Association, you clarified that such cases are to include situations where reports were made to the Medical Board of California pursuant to Section 805 or 821.5 of the Business and Professions Code, or were such reports were considered.

In response to that part of the letter, please be advised that the [redacted] and its Medical Staff report actions to the Medical Board as defined in the above-referenced statutes. During the period in question [redacted] and its Medical Staff reported two matters to the Medical Board. The first, involved Physician [redacted]' The circumstances relating to Physician [redacted], as reported to the Medical Board, were as follows:

> "On November 17, 2004, the Chief of Staff summarily suspended [Physician [redacted]] clinical privileges based on his assessment that failure to take that action would result in an imminent risk to patients. This action was based on Dr. [Physician [redacted]] failure to provide responsive and reliable responses to questions presented to him related to the Medical Staff's investigation of a maternal death case in which he was involved; evidence that [Physician [redacted]] had provided incomplete and misleading information in his applications to this facility; notice that the Medical Board of California has found that [Physician [redacted] has provided incomplete and misleading information to another licensing board and to other facilities; a history of malpractice claims and complaints arising out of [Physician [redacted]s] surgery practice; and concerns of substandard practice and poor judgment. On November 29, 2004, the Medical Executive Committee upheld the suspension following an informal interview with [Physician [redacted]]. [Physician [redacted]] has been notified of his right to request a hearing to review the suspension."
>
> "By letter dated December 6, 2004, [Physician [redacted]] filed a timely request for a Medical Staff hearing to review the summary suspension and recommended termination of his staff membership and privileges. The Medical Executive Committee issued an amended Notice of Charges. Before the hearing commenced, by letter dated February 14, 2005, [Physician [redacted]], through legal counsel, informed the Hearing Officer that he had withdrawn his request for hearing. Accordingly, the suspension and termination became final and [Physician [redacted]] was deemed to have waived his right to a hearing."

The second situation reported to the Medical Board involved "Physician [redacted]." The circumstances relating to Physician [redacted], as reported to the Medical Board, were as follows:

"By letters dated February 23, 2006 and March 16, 2006, [Physician [redacted]] was notified that the Department of Surgery had initiated an investigation of [Physician [redacted]] alleged abandonment of a patient whom [Physician [redacted] had evaluated and scheduled for emergency orthopedic surgery in January, 2006. [Physician [redacted] responded to the Department's letters by a letter dated April 20, 2006. Before the Department of Surgery and Medical Executive Committee had completed the investigation of the alleged incident, [Physician [redacted] resigned his Medical Staff membership and privileges by failing to pay staff dues."

Apart from the two situations described above, during the time in question, [redacted] had no situations in which a report to the Medical Board was either made or contemplated.

If you would like to discuss the question of "peer review cases" you may contact me.

Very truly yours,

[redacted]

[redacted]

Enclosures

cc: [redacted]

[redacted]

November 12, 2007

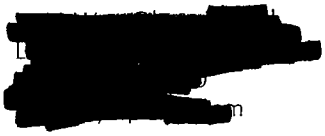
Lumetra
Jean Ann Seago, PhD, RN
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007, requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the 'peer review process" and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process" or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six-year period. (During the call, one participant noted that her facility had reviewed 8,100 medical records during that period!). Producing all of these records, and/or the documents and minutes of all the departments and committees that conducted reviews of the care rendered in all of these cases is an unreasonable, unfunded burden, no matter what timeframe is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are significant legal impediments to responding, some of which were also discussed during the call. While Section 805.2 limits access to the information disclosed to you, it does not exonerate the hospital from liability under other legal principles for making the disclosure. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Federal and state laws and regulations severely restrict hospitals from disclosing individually identifiable medical information. While we appreciate that Section 805.2 provides some level of protection after you receive these records, it does not address the legal obligations of the hospitals not to disclose such information.



[redacted]

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws
- Medical Staff bylaws
- Medical Staff rules and regulations
- Peer Review policies
- Section 805 reports filed between September 2001 and September 2007

Thank you for your understanding. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Via Overnight Mail
November 5, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing

[redacted]

the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] at [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

November 6, 2007

CERTIFIED MAIL

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Request for Peer Review Information/ [redacted]
Peer Review Study Authorized by Business and Professions Code, Section 805.2

Dear Dr. Seago:

This responds to your letter dated September 17, 2007, in which you state that [redacted] has been selected to participate in a study of peer review as authorized by Business and Professions Code, Section 805.2.

In your letter you asked for copies of [redacted]'s peer review documents. In response to that portion of the letter, I am enclosing copies of the following:

1. Medical Staff Bylaws of the Medical Staff of [redacted];
2. [redacted] Rules and Regulations of the Medical Staff;
3. [redacted] Medical Staff Policy and Procedure on "Peer Review Process;"

If you have any questions about these documents, you may contact [redacted].

[redacted]

[redacted]

In the letter you also asked for certain information related to "peer reviewed cases" for the period September 2002 through September 2007. In a phone conference on October 5, 2007, facilitated by the California Hospital Association, you clarified that such cases are to include situations where reports were made to the Medical Board of California pursuant to Section 805 or 821.5 of the Business and Professions Code, or where such reports were considered.

In response to that part of the letter, please be advised that the [redacted] and its Medical Staff report actions to the Medical Board as defined in the above-referenced statutes. During the period in question, [redacted] and its Medical Staff reported one matter to the Medical Board. A copy of the Health Facility Reporting Forms relating to that matter is enclosed

Aside from that matter, during the time in question, [redacted] had no situations in which a report to the Medical Board was either made or contemplated.

If you would like to discuss the question of "peer review cases" you may contact me.

Very truly yours,

[redacted]

[redacted]

Enclosures

cc: [redacted].

[redacted]

[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do

so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Medical staff/peer review provisions of the governing body bylaws
- Medical Staff bylaws
- Medical Staff rules and regulations
- Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
- Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
- Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:

  1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
  2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
  3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
  4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, medical staff office personnel and leaders at the Hospital have changed during the period covered by your request. Since the type of situations reported were not logged for this purpose, it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred, particularly if it preceded

their tenure.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

[redacted]

[redacted]
Enclosures

[redacted]

[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of

medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

A. Medical staff/peer review provisions of the governing body bylaws
B. Medical Staff bylaws
C. Medical Staff rules and regulations
D. Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
E. Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
F. Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:
    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
    2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
    3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

    However, upon review, none of the foregoing occurred during the above five year period.

[redacted]

[redacted]

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, since the type of situations reported were not logged for this purpose, it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

[redacted]

[redacted]

Enclosures

[redacted]

[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of

medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

A. Medical staff/peer review provisions of the governing body bylaws
B. Medical Staff bylaws
C. Medical Staff rules and regulations
D. Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
E. Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
F. Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:
    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
    2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
    3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

    However, upon review, none of the foregoing occurred during the above five year period.

[redacted]

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, since the type of situations reported were not logged for this purpose, it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

Enclosures

[redacted]

November 9, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Request for Peer Review Information/
Peer Review Study Authorized by Business and Professions Code, Section 805.2

Dear Dr. Seago:

This responds to your letter dated September 17, 2007, in which you state that [redacted] has been selected to participate in a study of peer review as authorized by Business and Professions Code, Section 805.2.

In your letter you asked for copies of [redacted]s peer review documents. In response to that portion of the letter, I am enclosing copies of the following:

1. "Medical Staff" and "Peer Review" provisions of the Board of Directors Bylaws;
2. Bylaws of the Medical Staff;
3. General Rules and Regulations of the Medical Staff;
4. Medical Staff Policy and Procedure on "Peer Review;"
5. Medical Staff Policy and Procedure on "Disruptive Behavior."

If you have any questions about these documents, you may contact [redacted]

In the letter you also asked for certain information related to "peer reviewed cases" for the period September 2002 through September 2007. I understand that in a phone conference on October 5, 2007, facilitated by the California Hospital Association, you clarified that such cases are to include situations where reports were made to the Medical Board of California pursuant to Section 805 or 821.5 of the Business and Professions Code, or were such reports were considered.

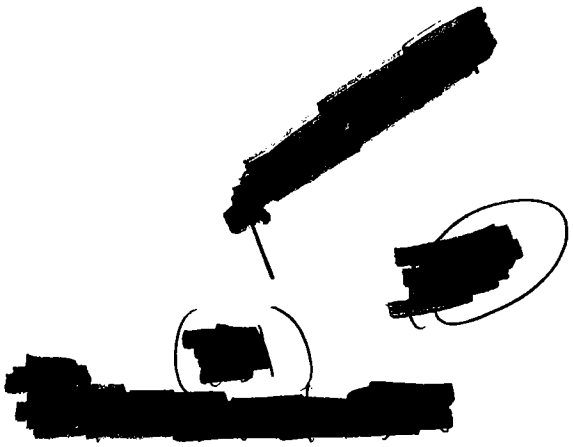
In response to that part of the letter, please be advised that the [redacted] and its Medical Staff report actions to the Medical Board as defined in the referenced statutes. During the period in questions there were no reports by this facility and no actions regarding which a report was considered.

If you would like to discuss the question of "peer review cases" you may contact legal counsel, [redacted].

Very truly yours,

[redacted]

[redacted]



November 2, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Your Letter of September 17, 2007

Dear Dr. Seago:

This will respond to your letter of September 17, 2007 requesting the production of certain documents from our facility. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, we understand that Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from "the last five years" (i.e. from September of 2002 through September of 2007). (We also understand that, during the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) For any hospital, producing copies of all of the requested records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases would be an unreasonably difficult burden, and [redacted] is no exception. Our Quality Management Department has estimated that, to provide you with a full chart containing all requested data would necessitate at least weeks of staff time, leaving the staff completely unavailable for vital quality assurance activities that must be performed on a daily basis. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and

[redacted]

sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing Body Bylaws.
- Medical Staff Bylaws.
- Medical Staff Rules and Regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2002 and November 2007**

** **Note:** A search of our files has revealed only one 805 Report filed during this time, a copy of which is enclosed. However, given that there has been tremendous turnover in staffing of the Medical Staff Office during the last five years, we will continue to search our files and, should any additional reports be uncovered, we will forward them to you promptly.

If Lumetra is interested in coming to our facility to learn more about our peer review process, including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]

cc: [redacted]

Enclosure

[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of

medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

A. Medical staff/peer review provisions of the governing body bylaws
B. Medical Staff bylaws
C. Medical Staff rules and regulations
D. Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
E. Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
F. Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:
    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
    2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
    3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, since the type of situations reported were not logged for this purpose,

it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

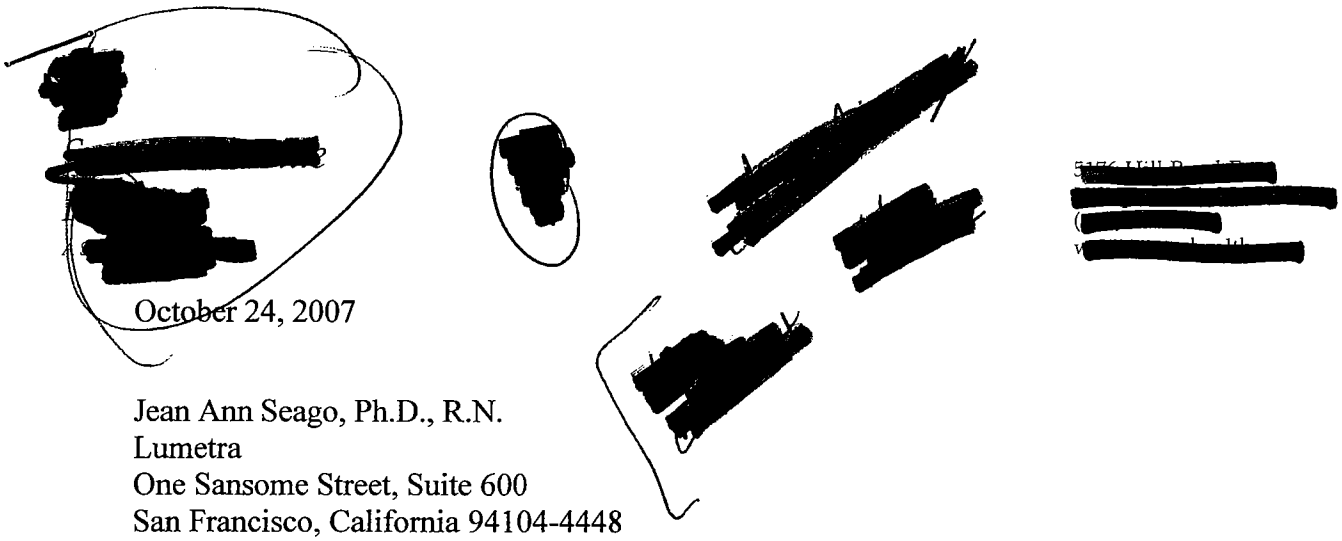
If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

[redacted]

[redacted]
Enclosures

[redacted]



October 24, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, California 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection

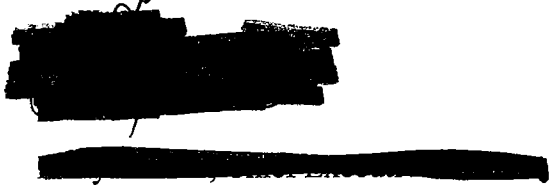
with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records — whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,



[redacted]

October 16, 1007

[redacted]

Jean Ann Seago, Ph.d.,R.N.
LUMETRA
One Sansome Street, Suite 600
San Francisco, CA 94101-4448

Dear Doctor Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records and /or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lantern-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents, and sent them offsite. To do so not only requires unreasonably

significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Section 80-5 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]

[redacted]
Administrator

[redacted]

[redacted]

November 9, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, California 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a five year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only require an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection

[redacted]

with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records — whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Sample Peer Review Sheets
- Minutes pertaining to the filing of 805 reports

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]

[redacted]

October 31, 2007

[redacted]

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, California 94104-4448

Dear Ms. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection

[redacted]

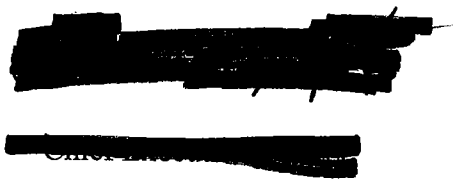
With respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records — whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations; however, the Medical Staff of Sutter Delta Medical Center does not utilize Rules and Regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007; Sutter Delta Medical Center did have one 805 report in October of 2006, however, due to our concerns regarding how these documents will be protected from further disclosure, we will not be sending these at this time. They will be here on site in the event you chose to come review them.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,



[redacted]

December 7, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of

medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

A. Medical staff/peer review provisions of the governing body bylaws
B. Medical Staff bylaws
C. Medical Staff rules and regulations
D. Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
E. Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
F. Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:
    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
    2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
    3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, since the type of situations reported were not logged for this purpose,

[redacted]

it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

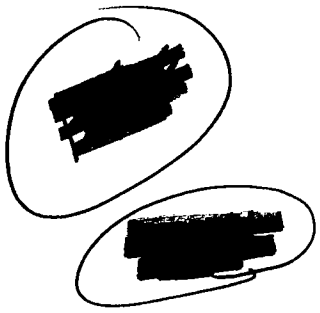
Sincerely,

[redacted]

Enclosures

[redacted]

[redacted]



December 3, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: Peer Review Study

Dear Dr. Seago,

It is the intention of [redacted] to cooperate to the best of our ability with the mission and intent of your study. We still find your request for "peer review" documents unclear. We have been advised that neither the applicable statute, nor Lumetra's letter, defines many key terms. We understand that on October 5, 2007 you participated in a conference call with a number of hospital representatives and stated that Lumetra does not intend to provide any additional written clarification of its request for documents, or the terms it uses in your letter of September 17, 2007. We also understand that during the call you instructed the hospitals to provide that information which each hospital believes to be responsive.

The September 17th letter Lumetra sent seems to misunderstand what is reported under California Business and Professions Code sections 805 and 821.5. Unless and until Lumetra narrows or clarifies its request to guide our response, we can only interpret the request as best we can to produce documents reasonably responsive to the expressly authorized scope and purpose of the study. We have, for instance, significant concern about Lumetra's request for five years worth of peer review minutes. Due to legal protections covering peer review, we have never copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, and other peer review documents, and sent them off site. The logistics of making such copies and sending them off site to a non-governmental agency not only requires a significant amount of resources and time, but it also greatly increases the risk that such copies will be disseminated --- intentionally or unintentionally---to third parties not involved in the Lumetra study. Such a breach in confidentiality would undermine the integrity of the peer review process. Although we recognize that the legislation provides some level of protection with respect to your maintenance of these records, it does not appear to guard adequately against others' access.

At this time we wish to note that the statute authorizing the study does not require hospitals to synthesize information into a table. Therefore, we have not entered data into Table 2 of your letter, in large part due to the table's lack of clarity. Your letter also asks [redacted] to explain how it "decides" whether or not to report a "case" to the Medical Board, pursuant to Section 805 or Section 821.5. We wish to clarify with you that "cases" are not reported to the Medical Board; rather, Section 805 requires hospitals to report a licentiate who is subject to a defined set of restrictions (often called "corrective actions"), and Section 821.5 requires hospitals to report formal investigations into whether a physician may be suffering from a disabling mental or physical condition that poses a threat to patient care. When [redacted] formally investigates, restricts or denies membership or privileges to a licentiate, it evaluates whether that action constitutes a reportable event under either statute. If the action does constitute such an event, then [redacted] files the appropriate report. If the action does not, the hospital does not file a report because a report is not required.

[redacted] has reviewed the corrective actions, including the recommendation to deny membership and/or privileges, which it has taken against licentiates since September 2001. [redacted] has filed Section 805 reports for every action that was reportable, as defined in the statute. The hospital also has reviewed whether any of its formal investigations would be 821.5 reportable. The hospital as filed an 821.5 report for a relevant investigation. Therefore, the hospital does not have any information to disclose about unreported actions.

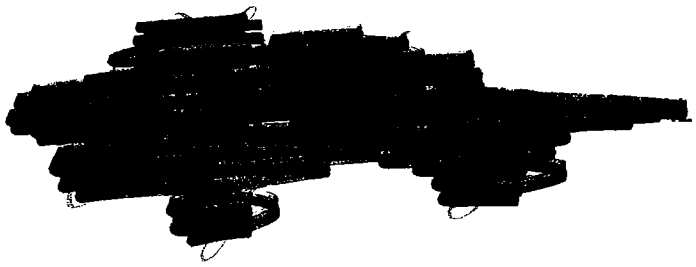
At this time, [redacted] therefore, is providing the following:

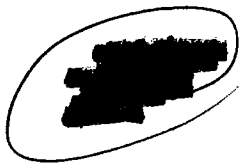
- [redacted] Bylaws [Attachment A]
- [redacted] Bylaws [Attachment B]
- [redacted] Staff Department Rules & Regulations [Attachments C1 through C7]
- [redacted] medical staff Peer Review Policy (currently under review) [Attachment D]
- (Sample) Occurrence Report form [Attachment E]
- Section 805 reports filed between September 2001 and September 2007 (except those filed for delinquent medical records) [Attachment F]
- Section 821.5 reports filed between September 2001 and September 2007 [Attachment G]

Please do not hesitate to contact us if you have any questions concerning [redacted]'s submission of documents. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]





October 31, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define "peer review process" or any other term, which causes significant confusion among California hospitals that have been selected to participate in the study.

On October 5, 2007, our staff participated in a conference call with you and numerous representatives of California hospitals in hopes of clarifying the scope of the study so that we could respond appropriately. However, Lumetra was not able to provide clarification of the terms "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for documents related to peer review from September 2002 through September 2007 as related to 805 reporting. Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left with no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

Due to the legal protections covering peer review, our concern is for the significant possibility that copies of peer review minutes will be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above (and in consultation with legal counsel), we have determined that we can provide Lumetra copies of the following documents:

- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2002 and September 2007.

If Lumetra would be interested in reviewing Medical Staff peer review minutes, our hospital asks that a representative come on-site to our facility to do so and learn more about our "peer review process". Please contact our [redacted] for an appointment at [redacted] if you desire to review these documents.

Thank you for understanding our response. We look forward to cooperating with you as best we can on this important project.

Sincerely,

[redacted]

[redacted]

Via Overnight Mail

October 23, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

[redacted]

the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

October 23, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study. We propose to provide two years worth of minutes from those committees which have direct responsibility for peer review with respect to physicians. Even this would be burdensome, but it can be accomplished in a reasonable timeframe.

Given the amount of material requested, provision of the information by October 8, 2007 was not possible. Moreover, the letter raises numerous issues which need to be addressed prior to the provision of any documents. Additionally, California Business and Professions Code Section 805.2(d) states that information shall be provided within a "...mutually agreeable timeframe".

[redacted] respects the purpose of the study Lumetra has contracted to undertake. Once the issues raised in this letter, and any others which may be identified during the process, are resolved, information will be forthcoming. However, the following must first be addressed:

1. The "peer review body" for purposes of your request is the [redacted] as defined in California Business and Professions Code Section 805(a)(1)(A). The

[redacted]

definition of a peer review body quoted in the letter is an incomplete and inaccurate paraphrasing of Business and Professions Code Section 805(a)(1)(D), which applies to large clinics and similar entities. Accordingly, records to be provided will be those of the [redacted]

2. The stature provides that peer review bodies are to furnish "...raw data, information, and case files" Section 805.2(d). The request for the [redacted] to prepare a compilation (Table 2) goes beyond the authorization contained in the statute.
3. The documents to be provided are confidential peer review materials protected by California Evidence Code Section 1157. The statute provides that all information Lumetra obtains shall be confidential. Business and Professional Code Section 805.2(e). Given the sensitivity of these materials, we want to know what safeguards / systems / policies Lumetra has implemented to assure that confidentiality is maintained. Moreover, the Lumetra letter contains no commitment, nor even any mention of, its responsibility to preserve the confidentiality of these materials. Such a commitment, along with a description of the safeguards that have been put into place, is a critical pre-condition to the provision of any material.

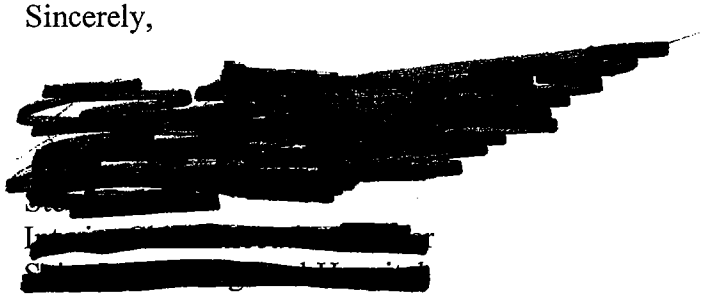
Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations.
- Peer review policies and procedures.
- All peer review reporting forms with any definition of terms used

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Thank you for understanding our response and your anticipated cooperation.

Sincerely,



[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, since Lumetra was not able to provide clarification of the terms used in the study or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, the Hospital was forced to interpret the request as best it could to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

As was discussed in the October 5, 2007 conference call, there are several legal impediments to responding. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of

[redacted]N

medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While the Hospital appreciates that the legislation provided some level of protection with respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

A. Medical staff/peer review provisions of the governing body bylaws
B. Medical Staff bylaws
C. Medical Staff rules and regulations
D. Medical Staff peer review policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
E. Medical Staff code of conduct policies and procedures or disruptive physician policies and procedures (if policies and procedures exist in addition to what is in the Medical Staff Bylaws and Rules)
F. Summaries, if during the five (5) year period from September 2002 through September 2007 any of the following occurred:
    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
    2. A summary suspension over 14 days or a restriction of 30 days or more was imposed.
    3. The MEC recommended disciplinary action that was grounds for a hearing based upon its determination that a licentiate's competence or professional conduct was reasonably likely to be detrimental to patient safety or to the delivery of patient care.
    4. Other situations that were reported to the MEC where a report to the MBC (as either an "805 Report" or "821.5 Report") was considered by the MEC (examples: MEC informed that a practitioner resigned, took a leave of absence, relinquished privileges after being notified that a recommendation was being made for reportable discipline).

The Medical Staff of the Hospital made good faith efforts to identify and summarize each of the foregoing situations. However, since the type of situations reported were not logged for this purpose,

[redacted]s

it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

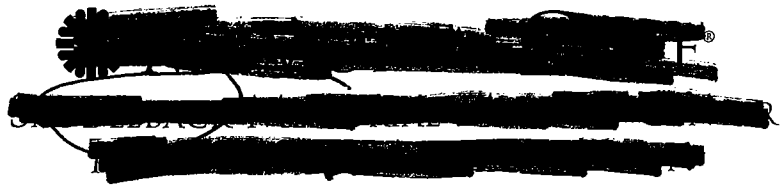
If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

[redacted]

[redacted]
Enclosures

[redacted]



October 30, 2007

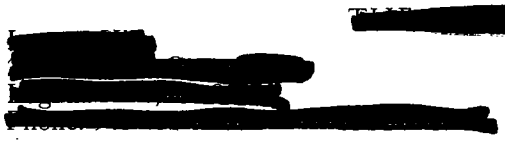
Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.



Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute::

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

November 5, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Lumetra's Request for Documents

Dear Doctor Seago:

Thank you for extending [redacted]s Lumetra response deadline to November 5, 2007. Enclosed are documents that [redacted] believes are responsive to Lumetra's September 17, 2007 request. Please note that although [redacted] intends to cooperate with Lumetra's peer review study, we still find Lumetra's request for "peer review" documents unclear. Neither the applicable statute nor Lumetra's letter defines many key terms and, in fact, in its request, Lumetra seems to misunderstand what is reported under California Business and Professions Code sections 805 and 821.5.

We understand that on October 5, 2007, you participated in a conference call with a number of hospital representatives and stated that Lumetra does not intend to provide any additional written clarification of its request or the terms it uses in the letter. We also understand that during the call, you instructed the hospitals to provide that information which each hospital believes to be responsive. Therefore, unless and until Lumetra narrows or clarifies its request to guide our response, we can only interpret the request as best we can to produce documents reasonably responsive to the expressly authorized scope and purpose of the study.

We should note that we have significant concern about Lumetra's request for five years worth of peer review minutes. Due to the legal protections covering peer review, we have never copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, and other peer review documents and sent them offsite. To make such copies and send them offsite to a non-governmental agency not only requires a significant amount of resources (and will take much longer than the November 5 deadline to gather and de-identify), it also greatly increases the risk that such copies will be disseminated – intentionally or unintentionally – to third parties not involved in Lumetra's study. Such a breach in confidentiality would undermine the integrity of the peer review process.

[redacted]

Although we recognize that the legislation provides some level of protection with respect to your maintenance of these records, it does not appear to guard adequately against others' access.

In light of the above, [redacted] has enclosed the following:

- Board of Trustees Bylaws
- Medical Staff Bylaws
- Medical Staff Rules and Regulations
- Blank Peer Review Form
- Peer Review Matrix
- The only Section 805 report the hospital filed between September 2002 and September 2007.

Please note that we were unable to collect and organize any other peer review documents by the November 5, 2007 deadline. Please also note that we did not agree to that deadline, and, as you know, Section 805.2(d) requires the hospital to respond within a "mutually agreeable" deadline. If [redacted] determines that there are other documents relevant to Lumetra's request, it will endeavor to provide those to you shortly.

Your letter also asks [redacted] to explain how it "decides" whether or not to report a "case" to the Medical Board pursuant to Section 805 or Section 821.5. As you may know, "cases" are not reported to the Medical Board; rather, Section 805 requires hospitals to report a licentiate who is subject to a defined set of restrictions (often called "corrective actions"), and Section 821.5 requires hospitals to report formal investigations into whether a physician may be suffering from a disabling mental or physical condition that poses a threat to patient care. If [redacted] formally investigates, restricts, or denies membership or privileges to a licentiate, it evaluates whether that action constitutes a reportable event under either statute. If the action does constitute such an event, then [redacted] files the appropriate report. If the action does not, the hospital does not file a report because a report is not required.

[redacted] has reviewed the corrective actions, including the recommendation to deny membership and/or privileges, which it has taken against licentiates since September 2002. [redacted] filed a Section 805 report for the one action that was reportable, as defined in the statute. The hospital also has reviewed whether it performed any investigations that would be 821.5 reportable. No such investigations were performed, so [redacted] has not filed any 821.5 reports. Therefore, the hospital does not have any information to disclose about Section 805 or Section 821.5 reportable actions that were not reported.

If you have any questions about [redacted]'s initial submission, please do not hesitate to contact me. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]

Enclosures

[redacted]

Via Overnight Mail

October 23, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

[redacted]

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
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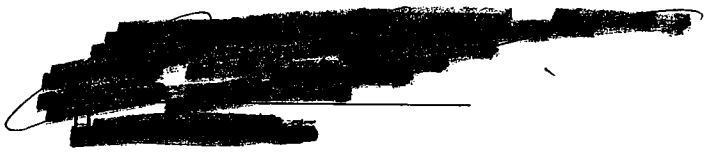
If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,



cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

November 5, 2007

VIA FEDERAL EXPRESS

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: [redacted]

Dear Dr. Seago:

This firm represents [redacted] ("Hospital") with respect to your letter dated September 17, 2007 that requested certain documents from the Hospital in connection with a study Lumetra agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

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    1. The Medical Staff's Medical Executive Committee ("MEC") received a request for corrective action under the corrective action provisions of its medical staff bylaws regarding particular licentiate(s).
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it is possible that the present personnel did not recall and were unable to identify, despite reasonable efforts, a situation that may have occurred.

If Lumetra is interested in coming to the Hospital to learn more about the Hospital's "peer review process," including a review of other documents and records involved in that process, please contact the undersigned for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

If you need to further discuss the Hospital's production, please contact the undersigned.

Sincerely,

[redacted]

[redacted]

Enclosures

[redacted]

[redacted]

[redacted]

Via Overnight Mail
10/30/07

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

We received your letter dated September 17, 2007, in which Lumetra has requested the production of certain documents from our facility in connection with a study Lumetra has agreed to perform on behalf of the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted with the Medical Board of California to conduct and report on the results of that study. Unfortunately, the statute does not define "peer review process", which has caused significant confusion among the California hospitals that have been selected to participate in the study.

On October 5, 2007, a conference call was held with you and numerous representatives of California hospitals in hope of clarifying the scope of the study so that responding facilities could participate in a meaningful way. However, Lumetra was not able to provide clarification of the "peer review process," or identify with more specificity what documents would be required to be produced

Production of all reviewed records, and/or the documents and minutes of all departments and committees that have conducted reviews of the care rendered in all cases is an extraordinary burden, no matter what time frame is involved. In addition, there are several legal impediments to responding that were discussed on the October 5th call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, because of the legal protections afforded peer review, to copy and produce years of medical staff minutes, reports, hearing transcripts, and other documents to a location offsite from the hospital would not only be unreasonably burdensome, but it would create the potential that such copies could be at risk for dissemination to third parties not involved in the study. While we appreciate that the legislation provided some level of protection with respect to the maintenance of these records, it does not appear to adequately guard against others' access to these records – whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, and the time frame within which to respond that was unilaterally established by Lumetra, we are producing

[redacted]

the following documents, which we believe are reasonably responsive to the request and that are within the authorized scope and purpose of the study as set forth in the statute:

- Governing body bylaws.
- Professional medical staff bylaws.
- Professional medical staff rules and regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact [redacted] for an appointment. Thank you for understanding our response. We look forward to cooperating as best we can to ensure the Legislature receives a report that adequately describes the "peer review process" in California.

Sincerely,

[redacted]

cc: [redacted]

Enclosure
Hospital Community Board Bylaws
Medical Staff Bylaws
Medical Staff Rules and Regulations
Peer Review Policies and Procedures
Section 805 Reports, September 2001 through September 2007

[redacted]

[redacted]

October 31, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, California 94104-4448

Dear Dr. Seago:

Your letter dated September 17, 2007 requested certain documents from our facility in connection with a study Lumetra has agreed to perform for the State of California. As we understand it, Section 805.2 of the Business and Professions Code authorizes that a study be conducted of the "peer review process," and Lumetra has contracted to conduct and report on the results of this study. Unfortunately, the law does not define that or any other term, which causes significant confusion among California hospitals that have been selected to participate in your study.

On October 5, 2007 a conference call was held with you and numerous representatives of California hospitals in hopes of clarifying the scope of your study in order for the responding facilities to participate in a meaningful way. However, Lumetra was not able to provide clarification of the terms used in the study, such as "peer review process," or identify with more specificity what documents would be required to be produced – other than to ask for "all" documents related to peer review from September 2001 through September 2007, a six year period. (During the call, one participant noted that her facility had reviewed 81,000 medical records during that period!) Producing all of these records, and/or the documents and minutes of all of the departments and committees that conducted reviews of the care rendered in all of these cases is an insurmountable burden, no matter what time frame is involved. Unless Lumetra is able to narrow or tailor its request to assist California hospitals to respond, we are left no option but to interpret the request as best we can to produce what appears to be reasonably responsive to the authorized scope and purpose of the study.

In addition, there are several legal impediments to responding that were also discussed on the call. Records relating to mental health under the Lanterman-Petris-Short Act, substance abuse, and HIV status are specially protected under the law, and Section 805.2 does not negate any of those protections. Moreover, due to the legal protections covering peer review, no hospital in California has ever, to our knowledge, copied and produced, on a wholesale basis, years and years of medical staff minutes, reports, hearing transcripts, and other documents and sent them offsite. To do so not only requires an unreasonably significant amount of manpower, it also raises the not insignificant possibility that such copies will be at risk for dissemination to third parties not involved in your study. While we appreciate that the legislation provided some level of protection

With respect to your maintenance of these records, it does not appear to adequately guard against others' access to these records — whether by subpoena or exercise of other governmental powers.

Accordingly, given the practical and legal concerns mentioned above, we have determined that we can provide Lumetra copies of the following documents:

- Governing body bylaws.
- Professional staff bylaws.
- Professional staff rules and regulations; however, the Medical Staff o[redacted] does not utilize Rules and Regulations.
- Peer review policies and procedures.
- Section 805 reports filed between September 2001 and September 2007; [redacted] did have one 805 report in October of 2006, however, due to our concerns regarding how these documents will be protected from further disclosure, we will not be sending these at this time. They will be here on site in the event you chose to come review them.

If Lumetra is interested in coming to our facility to learn more about our "peer review process," including a review of other documents and records involved in that process, please contact me for an appointment. Thank you for understanding our response. We look forward to cooperating with you as best we can on your project.

Sincerely,

[redacted]

[redacted]

MEDICAL STAFF BYLAWS

MEDICAL STAFF BYLAWS

[redacted]

DEFINITIONS

1. The term "allied health professional" or "AHP" is defined as an individual, not a member of the medical staff, who is trained in some aspect of the evaluation or treatment of human illness and who is allowed to perform specified services to patients at the hospital as delineated in their clinical privileges and in accordance with the bylaws and rules and regulations of the medical staff. MS.1.1.1

2. The term "Appellate Review Body" means the group designated pursuant to the Fair Hearing Plan to hear a request for appellate review.

3. The term "authorized representative" means the individual designated by the hospital and approved by the medical executive committee to provide and request information from the National Practitioner Data Bank.

4. The term "chief executive officer", or CEO, is defined as the individual appointed by the governing board to act on its behalf in the overall management of the hospital. The term "chief executive officer" includes a duly appointed acting administrator serving when the chief executive officer is away from the hospital. The medical staff may rely upon all actions of the CEO as being the actions of the governing board taken pursuant to a proper delegation of authority from the governing board.

5. The term "Clinical Pertinence" refers to the processes or outcomes of care associated with the delivery of clinical services allowing for intra and inter-organizational comparisons to be used to continuously improve patient health outcomes, focusing on the appropriateness of clinical decision making and implementation of these decisions. Monitoring is condition specific, procedure specific, and addresses important functions of patient care including medication use, infection control, patient assessment, utilization, etc.

6. The term "clinical privilege or "privilege" is defined as the permission granted to a medical staff member or allied health professional to render specific patient services.

7. The term "Discrimination or Harassment includes, without limitation, sexual harassment and discrimination or harassment against any individual on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, age, or sexual orientation.

8. The term "Disruptive Behavior includes any aberrant behavior which may reasonably appear to compromise quality of care either directly, or indirectly because it disrupts the ability of other professionals to provide quality care. Examples of Disruptive Behavior includes without limitation, (1) verbal abuse of any individual, (2) verbal abuse which is directed at large but is perceived by a member of a group to be offensive, (3) delaying the progress of surgery or other procedures to reprimand nurses or staff, (4) throwing instruments or other equipment, (5) making bad faith, false accusations of unprofessional behavior against any individual, or (6) any other aberrant behavior which may reasonably appear to compromise quality of care either directly, or indirectly because it disrupts the ability of other professionals to provide quality care.

9. The term "governing board" or "board" is defined as the group responsible for conducting the ordinary business affairs of the Hospital, which for the purposes of these bylaws, and except as the context otherwise requires, shall be deemed to act through the authorized actions of the Governing Board, the chief executive officer and other senior management of the Hospital.

10. The term "Hearing Committee" means the group designated pursuant to the Fair Hearing Plan to hear a request for an evidentiary hearing.

11. The term "hospital" means the two general acute care facilities which comprise Encino-Tarzana Regional Medical Center and all locations where the two facilities are licensed to provide outpatient services.

12. The term "Impaired Practitioner" refers to any individual who exhibits a physical, or mental condition which potentially impacts his or her medical/clinical judgment or professional conduct and which has or could be expected to adversely affect patient care.

13. The term "in good standing" relates to a medical staff member whom, at the time the issue is raised, is in compliance with the requirements of the medical staff bylaws and rules and regulations.

14. The term "mail" shall include any of the following methods of delivery:
    a. US Mail Service
    b. US Mail -Certified Return Receipt Requested
    c. Hand Delivery via Courier Service with signed receipt
    d. Private and/or Network Courier Service
    e. Private and/or Network Courier Service - Return Receipt Requested
    f. Hand delivery

    Mail shall be deemed delivered whether accepted by the doctor or the office personnel or not. Refusal by the doctor or the office personnel to accept the document will be considered equivalent to delivery and receipt.

15. The term " Medical Disciplinary Cause or Reason or MDCR" means that aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

16. The term "medical staff" is defined as that group of health care professionals who have been granted Medical Staff membership by the governing board.

17. The term "medical staff year" means the period from July 1 to June 30.

18. The term "member" is defined as any professional appointed to, and maintaining membership in, any category of the medical staff in accordance with these bylaws.

19. The term "Parties" means the practitioner who requests the hearing or appellate review and the body or bodies upon whose adverse recommendations or action a hearing or appellate review request is predicated.

20. The "patient" is defined as any person undergoing diagnostic evaluation or receiving medical treatment under the auspices of the hospital.

22. The term "patient contacts" shall be defined as inpatient admissions, surgical/operative and other invasive procedures, consultations including telemedicine, emergency consultations, pathologic and radiologic consultations, and surgical assisting.

23. The term "Practitioners" shall include the following licentiates who are eligible for Medical Staff membership: Doctor of Medicine, Doctor of Osteopathy degree, Dentists, Podiatrists, and Clinical Psychologists holding a license to practice in the state of California.

24. The term "routine monitoring" shall mean review of a member's practice for which the member's only obligation is to provide reasonable notice of admissions, procedures, or other contacts. All members of the medical staff, regardless of status, shall be subject to potential routine monitoring.

25. The term "telemedicine" refers to the use of electronic communication or other communication technologies to provide or support clinical care at a distance. Diagnosis and treatment of a patient may be performed via telemedicine link.

26. The term "telemedicine practitioner" refers to any licensed and appropriately credentialed practitioner who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient. The practitioner must have applied for and been granted telemedicine privileges.

ARTICLE I PURPOSE

The purpose of this organization is to bring the professionals who practice at the hospital together into a cohesive body to promote quality patient care. To this end, among other activities, it will assist in credentialing applicants for staff membership and privileges, review privileges of members and allied health practitioners, evaluate and assist in improving the work performed by the staff and allied health practitioners, provide education, and offer advice to the chief executive officer. The organization shall also be responsible for initiating and maintaining rules and regulations for self-governance of the staff and to provide a means whereby issues concerning the staff and the hospital, including but not limited to service quality may be discussed by the staff with the governing body and the chief executive officer. MS.1, MS.2.3.6 These bylaws do not constitute an express or implied contract between or among any individuals, committee or entity. The medical staff operates as a Professional Association within the meaning of Section 23701e of the California Revenue and Taxation Code. The medical staff organization does not contemplate pecuniary gain or profit to the members thereof and is organized for nonprofit purposes. Notwithstanding any of the above statements of purposes and powers, this medical staff shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of the specific purposes of the medical staff.

ARTICLE II. PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

I. PURPOSES

The purposes of the organization are:

A. To provide that all patients admitted to or treated in any of the facilities, departments, or services of the hospital shall receive quality care at a level established by the Medical Staff.

B. To assure appropriate professional performance of all practitioners authorized to practice in the hospital through delineation of clinical privileges that each practitioner may exercise in the hospital and through an ongoing review and evaluation of each practitioner's performance in the hospital;

C. To provide an appropriate educational setting that will maintain scientific standards and lead to continuous advancement in professional knowledge and skill;

D. To provide a means whereby issues concerning the staff and the hospital may be discussed by the staff with the governing body and the chief executive officer.

II. RESPONSIBILITIES

The responsibilities of the medical staff include:

A. To account for the quality and appropriateness of patient care rendered by all practitioners and allied health professionals authorized to practice in the hospital through the following measures:

1. A credentials program including mechanisms for appointment and reappointment and the matching of clinical privileges to be exercised, or of specific services to be performed with the verified qualifications, performance, credentials and current competence demonstrated by the applicant, staff member, or AHP.
2. A continuing medical education program, which addresses the needs demonstrated through the patient care monitoring and other quality maintenance programs and other issues identified from time to time.
3. An organizational structure that allows continuous monitoring and improvement of patient care practices.
4. Retrospective review and evaluation of the quality of patient care through a valid and reliable patient care monitoring procedure.

5. Participate in the monitoring of an effective utilization review program for the allocation of medical services based upon patient-specific determinations of individual medical needs.

B. To recommend to the governing board, action with respect to appointments, reappointments, staff category, provisional status, department assignments, clinical privileges, specified services for AHP's, corrective action and, as appropriate, department, service and/or unit assignment.

C. To communicate to the governing board regarding the quality and efficiency of medical care rendered to patients in the hospital through regular reports and recommendations concerning the implementation, operation and results of the patient care monitoring. Formal reports from the executive committee to the governing board shall be made at least quarterly, or more often if necessary.

D. To initiate and pursue corrective action with respect to practitioners, when warranted.

E. To develop, administer, and seek compliance with the medical staff bylaws, rules and regulations of the medical staff, and other medical care related hospital policies.

F. To assist in identifying and monitoring community health needs of all patients and assisting in the implementation of programs to meet those needs.

ARTICLE III. MEDICAL STAFF MEMBERSHIP

SECTION 1. MEDICAL STAFF MEMBERSHIP

Appointment to the medical staff of the hospital is a privilege that shall be extended only to professionals who provide a level of care required by the Medical Staff and continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated policies of the medical staff and hospital. Appointment to and membership on the medical staff shall confer on the member only such clinical privileges and rights as have been granted by the governing board in accordance with these bylaws. (See general rules and regulations for further delineation of requirements)

No individual is automatically entitled to initial or continued membership on the medical staff or to the exercise of any clinical privilege in the hospital merely because he or she is licensed to practice in this or any other state, because he or she has previously been a member of this medical staff, because he or she had, or now has membership or privileges at this or another health care facility or another practice setting, or because he or she is a member of any professional organization.

Medical staff membership does not create an employment or agency relationship between the practitioner and the hospital.

SECTION 2. QUALIFICATIONS FOR MEMBERSHIP

A. Except for emeritus staff, only physicians with Doctor of Medicine, or Doctor of Osteopathy degree, dentists, podiatrists, or clinical psychologists, holding a license to practice in the State of California, who can:
   1. document clinical background, experience, training, judgment, individual character, and current clinical competence
   2. document physical and mental capabilities (subject to any necessary reasonable accommodation),
   3. demonstrate ability to work cooperatively with others, refraining from Discrimination, Harassment, Disruptive and Unethical Behavior.
   4. demonstrate adherence to the ethics of their profession.
   5. Applicants shall also be required to possess a DEA with a full schedule (2,2N, 3, 3N, 4, 5), with the exception of Clinical Psychologists, Pathologists, Telemedicine physicians, and non-admitting category physicians.
   6. applicants must be able to demonstrate a history of timely completion of medical records.

7. comply with the rules and regulations and policies and procedures, which have been approved by the medical staff.
8. submit proof of his/her current professional liability insurance in amounts, not less than One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) per year or such amounts as may from time-to-time be recommended by the medical executive committee and approved by the governing board.

B. To be qualified for medical staff membership all new applicants for membership seeking clinical privileges (e.g. physicians, podiatrists, dentists and clinical psychologists) must:

Physician applicants (MD or DO) must have successfully completed an allopathic or osteopathic residency program of at least three (3) years, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be board certified or a board admissible candidate for an approved board of the American Board of Medical Specialties or the American Osteopathic Association in the specialty or sub-specialty of application. An exception to the above are Emergency Medicine Physicians who may be in the final six months of a residency in emergency medicine that is accredited by the Accreditation Counsel for Graduate Medical Education.

Oral and Maxillofacial Surgeons must have successfully completed a Commission on Dental Accreditation approved residency program or have successfully completed a minimum of twelve (12) months as a senior resident at an American Board of Oral and Maxillofacial Surgery program accredited by the Commission on Dental Accreditation, and be a board diplomate or a candidate to become a diplomate of the American Board of Oral and Maxillofacial Surgery.

Dentists must have graduated from an American Dental Association approved School of Dentistry accredited by the Commission of Dental Accreditation.

A Podiatrist (DPM), must have successfully completed a three year residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA) and be board certified or a board candidate of the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedic and Primary Podiatric Medicine.

Membership

Except for Clinical Psychologists, all applicants for medical staff membership must meet the qualifications in this section. Those members of the medical staff as noted above who are board candidates in their specialty or sub-specialty, must successfully achieve certification within five (5) years of staff appointment date. Failure to obtain board certification within the five (5) years shall result in automatic resignation of the practitioner's medical staff membership and clinical privileges without hearing rights. Practitioners who are applying to the medical staff within one year subsequent to voluntary resignation for administrative reasons shall not be required to meet the aforementioned requirement.

Clinical Privileges

For clinical privileges, physicians must be board certified or a board candidate in the specialty and sub-specialty in which the privileges are requested. If physician is a board candidate, board certification must be successfully completed within five (5) years of the time of appointment. Failure to obtain board certification within five (5) years shall result in specialty or sub-specialty privileges being deemed to have been automatically resigned without hearing rights. Practitioners who are applying to the medical staff within one year subsequent to voluntary resignation for administrative reasons shall not be required to meet the aforementioned requirement. (4/7/05)

C. Shall be located closely enough (office and residence) to the hospital to provide continuous care to their patients. Areas which are close enough shall be defined as areas which allow timely response to patient needs given the staff category, clinical privileges, and the proposed arrangements for alternative coverage.

D. Shall not be suspended, excluded, debarred, or sanctioned under the Medicare or Medicaid program or by any governmental professional licensing agency;

E. Demonstrate to the medical staff and governing board that any patient treated by them in the hospital or in any of its facilities will be given care of the professional level of quality and efficiency as established by the medical staff and hospital.

F. Conviction of a felony shall exclude the practitioner from being approved for membership and privileges.

G. Conviction of any healthcare related offense shall be grounds for exclusion of a practitioner from being approved for membership and privileges.

FAILURE TO DISCLOSE ANY ADVERSE INFORMATION MAY RESULT IN THE DENIAL OF MEMBERSHIP ON THE MEDICAL STAFF. OR IF MEMBERSHIP OR PRIVILEGES HAVE BEEN GRANTED, MAY RESULT IN CORRECTIVE ACTION UNDER THESE BYLAWS.

SECTION 3. NONDISCRIMINATION

The hospital and medical staff will not discriminate in granting staff appointment and/or clinical privileges on the basis of age, sex, race, creed, color, national origin, disability (unless such disability is such that reasonable accommodations could not be made in order to allow the practitioner to carry out privileges as requested), or other health care organizational affiliations.

Additionally, acceptance of membership on the staff shall constitute the staff member's agreement that s/he will admit and treat all patients on a nondiscriminatory basis, without regard to race, color, creed, religion, sex, race, age, disability or national origin.

SECTION 4. CONDITIONS AND DURATION OF APPOINTMENT

A. Initial appointments and reappointments to the medical staff shall be made by the governing board. The board shall act on appointments and reappointments only after there has been a recommendation from the medical staff in accordance with the bylaws and rules and regulations. (Requirements and process for appointment and reappointment are located in the rules and regulations of the medical staff)

B. Appointments to the staff will be for no more than twenty-four (24) calendar months as delineated in the Medical Staff Rules and Regulations.

Should any concern be identified during the credentialing process, recommendation may be made to provide "Conditional Appointment" in accordance with the medical staff rules and regulations. Should a practitioner who has been conditionally appointed fail to meet the requirements of the conditional appointment, they shall be voluntarily resigned from the medical staff without hearing rights, unless such resignation must be reported to the Medical Board of California, pursuant to California Business and Professions Code Section ξ 805.

C. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted by the governing board in accordance with requirements of the medical staff bylaws

D. Demonstration of participation in continuing medical education relating to privileges requested and approved. Continuing educational programs may include;
   1. Recertification by specialty board, as appropriate
   2. Courses in the basic sciences
   3. Educational credits towards the Physicians Recognition Award of the American Medical Association or other comparable programs.
   4. Publication of professional (research) programs
   5. Participation as an instructor or speaker in professional programs

6. Residency or fellowship training.

The number of continuing educational units shall be the same as those required to maintain current licensure.

E. Mandatory attendance at the Physician Orientation Program, for all new members of the medical staff is required within 9 months of the member being appointed by the Governing Board. Failure to attend a Physician Orientation Program during the specified period shall result in the physician being deemed a voluntary resignation without hearing rights; unless the physician can demonstrate good cause, with the approval of an exception at the discretion of the Chief of Staff or Designee. (3/04). Physicians who have been voluntarily resigned for administrative reasons, and are required to apply as new applicants, shall be exempt from this requirement. (6/06)

SECTION 5. STAFF DUES

A. Annual medical staff, allied health professional, and education staff, dues and fines shall be determined by the most recent recommendation of the Medical Executive Committee and approved by the Governing Board. Payment of dues may be waived under certain circumstances.

B. Emeritus and Non-Admitting staff members will not be required to pay dues, however Non-Admitting members shall be required to pay an application fee.

C. Physicians on leave of absence shall not be required to pay medical staff dues during the period during which they are on a leave. They shall be assessed dues at the time of return if reappointment is requested.

D. Dues shall be payable by July 1st of each year. If the Medical Staff office has not received Medical Staff Dues by 5:00 p.m., July 1 (or if July 1 falls on a weekend, then the next business day), the practitioner's Medical Staff membership and clinical privileges shall be automatically suspended as of 5:00 p.m., July 1 (or if July 1 falls on a weekend, then 5:00 p.m. on the next business day). If the Medical Staff office does not receive the delinquent dues within three (3) months of the due date, the practitioner shall be deemed to have voluntarily resigned from the Medical Staff without any hearing rights.

E. Physicians who have not paid medical staff dues by July 1st or the first business day following, and have been placed on automatic suspension shall be required to pay the amount of the dues plus a late fee equal to the amount of the original dues payment.

SECTION 6. RESPONSIBILITIES OF MEMBERSHIP

Except for emeritus members and non-admitting staff who do not have any clinical privileges, each medical staff member shall continuously meet all of the following responsibilities:

A. Direct the care of his or her patients and supervise the work of any allied health professional(s) under his/her direction as per the bylaws and rules and regulations of the medical staff.
B. Act in an ethical, professional, and courteous manner, while providing his/her patients with care of the generally recognized professional level of quality and efficiency.
C. Treat employees, patients, visitors, and other physicians in a dignified and courteous manner, refraining from any unlawful harassment, disruptive behavior, or discrimination against any person (including any patient, hospital employee, volunteers, hospital independent contractor, medical staff/allied health professional member, or visitor) based upon the person's age, sex, religion, race creed, color, national origin, health status, ability to pay, or source of payment.
D. Abide by the medical staff bylaws, rules and regulations, and hospital policy.
E. Discharge such medical staff, department, section, committee, and service functions for which s/he is responsible by appointment, election, or otherwise.
F. Prepare and complete, in timely manner, the medical and other required records for all patients to whom the practitioner in any way provides services in the hospital.
G. Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.
H. Seek consultation whenever warranted by the patient's condition or when required by the rules and regulations of the medical staff.

I. Actively participate in and cooperate with the medical staff in assisting the hospital to fulfill its obligations related to patient care, including, but not limited to, performance improvement, peer review, utilization management, quality evaluation and related monitoring activities required of the medical staff, and in discharging such other functions as may be required from time to time.

J. Upon request, provide information from his/her office records or from outside sources as necessary to facilitate the care of, or review of the care of specific patients.

K. Communicate with appropriate medical staff officers and/or departmental chairs, or well-being committee chair, when s/he obtains credible information indicating that a fellow practitioner may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients, and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

L. Must participate in proctoring in accordance with the rules and regulations of the medical staff.

M. Participate in sufficient continuing medical education in order to meet all licensing requirements and is appropriate to the practitioner's specialty.

N. Each medical staff member shall be required to promptly inform the medical staff whenever there are:

1. any changes to a member's physical or mental health status that affect his/her ability to perform his/her privileges~~,~~
2. if there are any monetary settlements, or judgments wherein professional malpractice is alleged, any cancellation or restriction of professional liability coverage, or
3. any and all adverse actions or commencement of any actions listed in ARTICLE VIII, Section 2. (1-11) of these bylaws by another hospital, health care facility or other peer review body, any actions taken by any medical society, licensing board, or the DEA to restrict, suspend, revoke, impose probation or limit the member's professional activities.

Failure to report any of the above changes shall result in immediate loss of medical staff membership and clinical privileges and would require the physician to apply as a new applicant. Application may not be made for a minimum of one (1) year following the loss of membership, unless excused for demonstrated good cause. Loss of membership, pursuant to this Section 6N, and clinical privileges based upon failure to report is not subject to hearing or appeal, unless it must be reported pursuant to California Business and Professions Code Section 805.

O. Demonstrate satisfactory current health status, which may include but not be limited to, mental and/or physical examination, including but not limited to, body fluid testing, by a professional designated by the Medical Executive Committee if the Medical Executive Committee determines there is a reasonable concern that a member's mental or physical health status may interfere with his ability to exercise privileges which have been granted or requested or to fulfill essential responsibilities of the Medical Staff or if the Medical Executive Committee determines it needs additional information to evaluate potential accommodations to enable the physician to exercise such privileges and fulfill essential responsibilities. Failure to comply with the request by the Medical Executive Committee within a reasonable time as designated by the Medical Executive Committee shall result in the appointment/reappointment being considered incomplete.

P. Maintain the confidentiality of all medical staff peer review matters <u>and</u> all individual patient identifiable information in accordance with State and Federal regulations and pursuant to these bylaws.

Q. Authorize the hospital and medical staff to consult with and receive information and documents from members of the medical staffs of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, skill, character, ethics, and other qualifications.

R. Consent to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications for clinical privileges he/she requests as well as his/her moral and ethical qualifications for staff membership.

S. Release all persons from any liability for their actions performed in connection with the investigation and evaluation of the applicant and his/her credentials and all individuals and organizations who provide information regarding the applicant, including otherwise confidential information.

T. Consent to disclosure to other health care entities, medical associations, licensing boards, and other organizations any information regarding his/her professional or ethical standing that the hospital or medical staff may have, and release the medical staff and hospital from liability to the fullest extent permitted by laws.

U. To complete proctoring within one year of membership. Physicians who do not complete proctoring within one year shall be deemed a voluntary resignation, without hearing rights. Subsequent to the completion of proctoring, the physician shall be required to serve on the Emergency Call Panel, if requested for a two-year period. Coverage may be required up to ¼ of the month, if necessary. (7/06)

V. Provide copies of medical records and office records requested by the Medical Staff for review as part of the credentialing or peer review process.

W. Attendance at Physician Orientation is mandatory for all new members of the Medical Staff within 9 months of their appointment by the Governing Board. Failure to attend will result in the physician's voluntary resignation, without hearing rights, unless the physician can demonstrate good cause and receives approval of exception from the Chief of Staff or designee. (4/04)

SECTION 7. CLINICAL PRIVILEGES

A. Clinical privileges are to be delineated for every practitioner by the appropriate clinical department. Every practitioner providing direct clinical services, including but not limited to telemedicine services at this hospital shall be entitled to exercise only those clinical privileges specifically granted to him/her by the appropriate clinical department and approved by the governing board, except as provided in Article IX, Section 7 for emergency privileges. Under no circumstances shall clinical privileges be granted solely upon board certification, fellowship, or membership in a specialty, body, or society. Such clinical privileges may be probationary, may require adequate supervision or approval, or be otherwise qualified or limited at the discretion of the governing board.

B. Every initial application for staff appointment, whether for medical staff, allied health professional staff, telemedicine, or locum tenens privileges, shall contain a request for the specific clinical privileges desired by the applicant. The evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated competence, references, and other relevant information including an appraisal by the department in which such privileges are sought. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges s/he requests.

C. The privilege processing shall begin in the Credentials Committee, confirmed and/or further defined by the appropriate clinical department. The clinical department shall determine the review or observation procedures to be used in the department which shall consist of a significant number of cases reviewed and observed. The observer or proctor may act as an assistant.

The applicant shall acknowledge the right of the proctor to take over the case whenever the proctor feels it is necessary to safeguard the patient's health and well-being. The applicant shall have no cause to complain against the proctor who acts in good faith and without malice. This provision shall not constitute a restriction of the member's privileges and shall not constitute grounds for appeal based on this action.

If the clinical department has a standing peer review committee, that committee shall report its recommendations to the clinical department and the clinical department shall in turn report to the Medical Executive Committee as to whether the provisional status of the applicant for medical staff is to continue. This duration shall not be longer than permitted for provisional appointments. If the recommendation is to advance the practitioner from provisional staff status, the clinical departmental report shall recommend the applicant's proposed staff status. If the applicant is to remain subject to ongoing proctoring, the report shall include which clinical privileges shall continue to be proctored.

D. Periodic re-determination of clinical privileges may be based upon the direct observation of care provided, review of the records of patients treated at the practitioner's office, at this or other facilities, and review of records which document or evaluate the member's current participation in the delivery of care for the desired privileges.

CLINICAL PRIVILEGES FOR ORAL SURGEONS AND DENTISTS

Privileges granted to oral surgeons and dentists shall be based on training, experience, education, and demonstrated competence, judgment, and health status as it pertains to the ability to practice in the area privileges are sought. The scope and extent of surgical procedures that each oral surgeon and dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by oral surgeons and dentists shall be under the overall supervision of the chief of surgery. All oral surgery and dental surgery patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the staff shall be responsible for admission history and physical and the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. An oral surgeon or dentist is responsible for the part of a patient's history and physical examination that relates to oral surgery or dentistry.

Oral surgeons may admit a patient to the hospital for a surgical procedure.

Dentists may not admit patients to the hospital. They may consult on patients and perform procedures as requested by a physician member of the medical staff.

III. CLINICAL PRIVILEGES FOR PODIATRISTS

Privileges granted to podiatrists shall be based on training, experience, education, and demonstrated competence, judgment, and health status as it pertains to the ability to practice in the area privileges are sought. The scope and extent of surgical procedures that each podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists shall be governed by the requirements of the department of surgery rules and regulations. A physician member of the staff shall be responsible for admission history and physical and the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. A podiatrist is responsible for the part of the patient's history and physical examination that relates to the podiatric problem.

A podiatrist may admit a patient to the hospital for surgical procedure.

SECTION 8. EXCLUSIVE CONTRACTS, SELECTION & TERMINATION

DECISION TO INITIALLY GRANT AN EXCLUSIVE CONTRACT

A decision to close a department or service pursuant to the granting of an exclusive contract shall be made by the board, subject to the terms and conditions set forth in this section and in accordance with State and Federal law. Prior to deciding whether to close a department or service pursuant to an exclusive contract, the board, through the chief executive officer, shall notify the medical executive committee, each department chair and each practitioner whose clinical privileges would be subject to the proposed exclusive contract that the board is considering awarding an exclusive contract for the designated services. The notice shall be in writing and provide each of the recipients at least thirty (30) days notice of the date, time, and place of the meeting of the board or its appointed committee, which shall be convened to receive comments and recommendations regarding the proposed exclusive contract. The notice shall inform the recipients that comments shall be restricted to the appropriateness of granting the exclusive contract and that testimony shall not be permitted regarding the qualifications of individual practitioners. The notice shall also invite members of the medical staff to submit written comments regarding the proposed exclusive contract.

After evaluating information provided to it, the board shall determine whether to grant the proposed exclusive contract, considering whether less extreme measures would address

or remedy the medical staff and board's concerns. The board shall not act in an arbitrary or capricious manner in the conduct of its review or in making its determination.

SELECTION

A. The Medical Staff, through its medical executive committee, shall establish the quality of care criteria and evaluate the quality of any proposed hospital-based physicians or medical groups, e.g. radiology, pathology, anesthesiology, emergency medicine, and any physician(s) or medical group(s) who shall contract with the hospital to provide clinical services or to become a director of a clinical service.

B. The governing board, through the hospital administration, shall submit the names, to the medical executive committee, of any physician(s) or medical group(s) who or which is being considered by the governing board to contract with the hospital as hospital-based physicians, to provide clinical services or to become a medical director of a clinical service.

B. Within sixty days after receipt from the governing board of the name(s) of the proposed contract candidate(s), the medical executive committee shall submit its recommendation to the governing board. In the case of more than one candidate being submitted by the governing board, the medical executive committee may approve more than one candidate and may, but need not, indicate its preference. If none of the candidates submitted are approved, the governing board shall submit new candidates for evaluation. If the medical executive committee fails to make a recommendation within the sixty days, the medical executive committee shall be deemed to have approved each of the proposed contract candidates, unless the governing board excuses the delay based upon a finding of good cause. The governing board shall make the final selection of candidates from among all approved candidates. The governing board, through the hospital administration, has the exclusive right to negotiate contractual fees, hiring, and termination of contracting physicians or medical groups.

C. Prior to making its report and recommendation, the medical executive committee shall submit the candidates' names to the credentials committee for its review and evaluation of the candidates' professional qualifications and suitability. The credentials committee shall submit a report and make recommendations to the medical executive committee within sixty days of receipt of the names by the medical executive committee. Consideration of qualifications and suitability to contract with the hospital shall include:

1. **the** experience of the candidate consistent with the needs and requirements of the hospital
2. the administrative and supervisory abilities in the candidates' specialty
3. the candidates compatibility with the medical and hospital staff to render effective patient care
4. whether the consultative and diagnostic techniques of the candidate meet the professional requirements of the medical staff in order to render quality effective patient care; and
5. other criteria as may be deemed appropriate.

D. This review and evaluation shall be independent of and without prejudice to any candidates' or candidates' employee's application for medical staff membership. Such application for medical staff membership shall be in accordance with the requirements of these bylaws. A determination or recommendation by the medical executive committee shall be final and without right of appeal by the candidate.

TERMINATION/REDUCTION OF PRIVILEGES

Prior to the hospital's unilateral termination of a contract with a hospital-based physician or medical group, the chief executive officer shall formally consult with the medical executive committee.

Practice at the hospital is always contingent upon continued medical staff membership, and is also dependent on the clinical privileges granted. The right of a practitioner who is

providing contract services to practice at the hospital is automatically terminated when his/her staff membership expires. Similarly, his or her right to render services under the contract is automatically limited to the extent that his/her clinical privileges are reduced, restricted, or terminated.

Physician may apply for privileges not under exclusive contract.

ARTICLE IV. APPLICATION FOR APPOINTMENT

A. Upon receiving a request for an application to the medical staff, the medical staff office shall ask the applicant to specify the general area of clinical privileges for which the individual wishes to apply. If all of the clinical privileges so identified are not available at hospital or are the subject of an exclusive contract or a closed service, the medical staff office shall so advise the individual and no application shall be provided the individual. If some of the clinical privileges so identified are not available or are the subject of a closed service or exclusive contract, but other privileges are available, the medical staff office shall so advise the individual. Applications will only be issued to candidates who seek privileges which are available to be exercised at the hospital. The individual shall not be entitled to a hearing pursuant to Article VIII, due to the refusal to provide such individual an application. Notwithstanding the foregoing, if the individual or group which holds the exclusive contract or has the right to exclusive use informs the medical staff office that the applicant is or shall be allowed to exercise the privileges which are the subject of the exclusive contract or exclusive use policy, subject to the credentialing process, the medical staff office shall provide the individual with an application.

B. All applications for appointment to the staff shall be:
   1. Completed legibly;
   2. Signed by the applicant;
   3. Shall be submitted on a form prescribed by the governing body after consultation with the executive committee
   4. Contain applicant's specific acknowledgment of his/her obligations to provide continuous care and supervision of patients, to abide by the medical staff bylaws, rules and regulations, to accept committee assignments, to accept consultation assignments, to abide by current hospital policies that apply to activities as a medical staff member.

C. The application form shall require detailed information which shall include, but not be limited to the following:
   1. Applicant's professional qualifications including undergraduate education, postgraduate education and professional degrees, internship, residency/fellowship, all past and present hospital and other healthcare entity affiliations, membership in professional associations, societies, academics, colleges, and faculty/training appointments, specialty board certification, state licensure(s) with expiration date(s), DEA;
   2. Names of at least three (3) persons who have had experience in observing and/or working with the applicant and who can provide adequate references pertaining to the applicant's ethical character, current competence, health status (subject to any necessary reasonable accommodation to the extent required by laws), and the ability to work cooperatively with others. These individuals should be peers of the applicant and shall not be family members. The peer should be someone who is not financially affiliated with the physician. The appropriate clinical department and/or credentials committee may request additional references if deemed necessary.
   3. Responses to the following questions:
      a. Has any professional license of yours, in any jurisdiction, or your DEA registration ever been denied. limited (either voluntarily or involuntarily), suspended revoked, voluntarily surrendered or otherwise acted against or is any such action pending?
      b. Have your clinical privileges (including, but not limited to temporary, locum tenens, admitting, consulting, and assisting) or membership at any

health care facility ever been limited, suspended, reduced, denied, modified, revoked, not renewed, voluntarily relinquished or limited, or otherwise adversely acted upon or is any such action pending?

c. Have you ever been convicted of a felony or misdemeanor (other than minor traffic offenses) or is any such action pending? Have you ever entered into a plea agreement to avoid conviction of a felony? On a separate piece of paper list the details and the court involved.

d. Are there any professional liability cases pending against you or has any judgment or settlement been made against you in a professional liability case? If so, on a separate sheet, list the complete case name, the court in which the case was filed, the date of loss, the date you first received notice of the claim, the date of resolution, your insurance carrier and the amount of judgment or settlement paid on your behalf for each judgment or settlement.

e. Other than the cases described in response to the preceding question in which a professional liability case is pending or a judgment or settlement has been made, has any professional liability insurance claim been filed against you or have you reported any malpractice claims to your insurance carrier or have you received any letter of intent to sue?

f. Has any professional liability insurance carrier canceled, refused coverage, excluded specific procedures from your coverage, or has your insurance been rated up or has a surcharge been imposed by your insurance carrier, or is any such action pending?

g. Have you ever discontinued practice for any reason (other than for routine vacation or formal education/training) for one month or more? The applicant must account for all time gaps.

h. Have you ever been suspended, excluded, debarred or sanctioned under the Medicare or Medicaid program or by any professional governmental licensing agency, convicted of an offense related to health care, or listed by a federal or state agency as debarred, excluded, or otherwise ineligible for federal or state program participation?

i. Do you have any physical and/or mental health issues which cannot be reasonably accommodated and which may inhibit or otherwise impact your ability to meet your obligations under these bylaws, and exercise the clinical privileges requested, safely and competently? On a separate sheet of paper, please specify any accommodations which you may require and the basis thereof.

j. Have you ever had a reduction of privileges or formal counselings during any training program? If so, the applicant may be excluded from being granted staff membership based on the outcome of review of the circumstances of such action. Full disclosure is required.

D. Every application for staff appointment shall be accompanied by:

1. Photostatic copies of applicant's licenses to practice (upon application);
2. A photostatic copy of applicant's narcotics license, if applicable;
3. Continuing medical education activities reflecting documentation pertinent to privileges requested;
4. A non-refundable application fee;
5. Copy of current certification as required by the clinical department (e.g. ACLS, PALS, Certificate of Neonatal Resuscitation)
6. Evidence of current malpractice insurance coverage in amounts as set forth in these bylaws and as approved by the governing board;
7. All information requested regarding professional liability history for the past ten years, including final judgments or settlements made against the applicant in professional liability cases and any filed cases pending;
8. Proof that the applicant maintains appropriate clinical coverage in the hospital's service area (covering physician must hold like privileges);
9. A written statement, executed by the applicant acknowledging his/her agreement to comply with all applicable bylaws, rules and regulations, policies, requirements and standards adopted by the medical staff at the hospital;

10. A copy of Fluoroscopy licensure for physicians wishing to use Fluoroscopy;
11. A signed copy of the Medical Staff Expectations
12. Medicare Attestation (signed)
13. A signed and dated confidentiality statement
14. A list of cases treated or procedures performed to support privilege request, if requested.
15. Copy of medical board certification (if certified).
16. Consent to undergo a criminal background check.

E. Neither the medical staff office, medical staff, nor governing board shall have any obligation to review an application until the application is complete in all respects and the applicant submits all required information and supporting material. Any committee or individual charged under these bylaws with the responsibility of reviewing an application for appointment, reappointment, or new clinical privileges, may, upon review of the application, deem any such application incomplete. The fact that an application is deemed completed by the medical staff office or a department or committee does not preclude a committee or department, which subsequently reviews the application from deeming it incomplete. If an application is deemed incomplete, it will not be processed. The committee or department that deems an application incomplete shall request further documentation or clarification from the applicant. Such committee or department requesting further documentation or clarification shall notify the applicant in writing and shall afford the applicant a set period of time. Such period of time shall be established by the requesting body but shall not exceed sixty (60) calendar days from receipt of the request for information. Failure of an applicant to timely produce all of the requested information, documents, and explanations shall result in the application being deemed incomplete and voluntarily withdrawn. Unless required by applicable law, such action shall not result in the filing of the report with the applicable state licensing agency nor the National Practitioner Data Bank and shall not be grounds for a hearing. However, if within thirty (30) days of notification of the withdrawal of the application, the applicant requests an appearance before the medical executive committee, the applicant shall be permitted to appear before the medical executive committee to demonstrate good cause for the failure to provide the requested information. An applicant whose application was deemed withdrawn and not excused by the medical executive committee may not apply again to the Medical Staff for one (1) year following the date the application was deemed withdrawn. Any subsequent application submitted by the practitioner shall be processed as the initial application under these bylaws and must be accompanied by another initial application fee.

F. The medical staff office shall verify the information required in Sections 1B and 1C of this Article and seek any additional information as requested by the credentials committee, executive committee or clinical department. The hospital's authorized representative shall query the national practitioner data bank regarding the applicant member and submit any resulting information to the credentials committee for inclusion in the applicant's credentials file. The applicant shall be notified of any problems in obtaining the information required.

G. It is the applicant's obligation to assist the medical staff in obtaining the required information, if so requested. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics and other qualifications, and for resolving any doubts about such qualifications. The applicant is required to submit any evidence of current mental or physical health status that may be reasonably requested by the executive committee and may be required to submit to a physical examination or psychiatric evaluation by a practitioner designated by the medical staff.

Significant misrepresentation or omission of information in the application process shall be grounds for denial of the application, or if membership or privileges have been granted, for corrective action under these bylaws.

H. After collecting the references and other material deemed pertinent, the medical staff office shall transmit the application and all supporting materials to the credentials committee and the appropriate department(s) for evaluation.

I. By applying for appointment to the staff, each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the hospital to consult with members of the medical staff of other hospitals with which the applicant has been associated and with others who may have information bearing on his/her competence, character and ethical qualifications, consents to the medical staff's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges s/he requests or which pertain to his/her moral and ethical qualifications for medical staff membership, and releases from liability all representatives of the hospital and its medical staff for the acts performed in good faith and without malice in connection with the evaluation of the applicant and his/her credentials and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character, and other qualifications for staff appointment and clinical privileges, including otherwise privileged and confidential information.

J. The application form shall include a statement that the applicant has received the bylaws, rules and regulations of the medical staff, that s/he agrees to be bound by the terms thereof and the current hospital policies that apply to his/her activities as a medical staff member that are consistent with the medical staff bylaws.

K. The application shall include a statement wherein the applicant verifies that all answers, statements and information provided by the applicant on the application and during the application review process are and will continue to be true and correct, that the applicant will promptly update such answers, statements and information provided on the application or in the application review process, and that any material omission or misstatement on the application or in the application review process shall be grounds to deny the application or to terminate privileges.

L. Individuals whose function is medico-administrative in nature must apply for medical staff membership. The applicant shall be appointed through the same procedure used for all other medical staff applicants.

M. If the applicant does not complete the application within 90 days after submission of an incomplete application, the applicant shall be notified that his/her application will be filed as incomplete in 30 days, and that if s/he wishes to reapply after that date, a new medical staff application will be required and additional application payment fee equal to that of the original application fee required.

ARTICLE V. APPOINTMENT PROCESS

A. All applications shall require verification directly from the sources, provided however, if the American Medical Association reports that it has verified the reference the Medical Staff may elect to not further pursue verification directly from the source. The verifications which must be obtained, and those items for which the Medical Staff Office might accept verification from the AMA are:

1. Licensure to be verified directly with the Medical Board of California. All other state licensures shall be verified with the individual state agencies;
2. Malpractice coverage and claims history to be verified with the carrier directly;
3. National Practitioner's Data Bank, queried directly;
4. American Medical Association;
5. Professional medical references (peer references), queried directly;
6. Medical School (AMA statement that reference was verified may be sufficient);
7. Internship(s) (AMA statement that reference was verified may be sufficient);
8. Residency(s) (AMA statement that reference was verified may be sufficient);
9. Fellowships, if applicable;
10. ECFMG, if applicable, queried directly;
11. Hospital affiliations, current and past, queried directly;
12. Any other professional training or experience disclosure on the application;
13. FACIS –Criminal Background Evaluation, queried directly;
14. Any other information deemed necessary by the Medical Staff Office

15. To ensure that the individual requesting approval is the same individual applying for medical staff or allied health staff membership and privileges, the applicant shall be required to following the process below:
    a. Applicant is required to arrange a time with the Medical Staff Office for an in-person identification verification via photo ID through a valid United States issued ID. A current expiration date must be noted on the photo ID.
    b. Before the application is forwarded to the Credentials or Interdisciplinary Practice Committee, the applicant must present to the Medical Staff Office with the valid photo ID. No application will go forward to the Credentials or Interdisciplinary Practice Committee without this documentation in the Credential File.
    c. The Medical Staff Office staff will document, via completion of the Positive Identification Process Form, that positive identity was confirmed.

    Failure to provide proof of identity during the credentialing process will constitute an incomplete application and will be considered withdrawn. (4/04)

B. Once the application is deemed complete by the medical staff office, the credentials committee shall:
    1. Determine whether the application is complete or if additional information or documentation should be obtained in order to enable the committee to make its recommendation;
    2. Forward the applicants request for specific clinical privileges to the department or departments with jurisdiction over those privileges

C. Application Processing

As soon as practical after receipt of the complete application for membership, the credentials committee shall examine the evidence of character, professional competence, qualifications, and ethical standing of the practitioner. The committee may elect to interview the applicant and seek additional information. It shall determine, through information contained in references given by the practitioner and from other sources available to the credentials committee, whether the applicant has established and met all of the membership requirements. The credentials committee shall make a written report of its investigation and forward it to each clinical department wherein the applicant is seeking clinical privileges. The report shall include a recommendation that the practitioner be provisionally appointed to the medical staff, be rejected for medical staff membership (including the reason for rejection), be conditionally appointed (as defined in the rules and regulations), or that the application be deferred for further consideration. The clinical department(s) in which privileges have been requested shall review the credentials committee's report and recommendations. Each department shall make a written report, including specific written recommendations for delineating the practitioner's clinical privileges. The clinical departments shall transmit to the executive committee the completed application, the departments report and the credentials committee report.

The executive committee will resolve any conflicts as to which privileges fall within the jurisdiction of which departments.

D. If practical at its next regular meeting after receipt of the application, report and recommendation of the credentials committee and each of the clinical departments, the executive committee shall determine whether to recommend to the governing board that the practitioner be provisionally appointed to the medical staff, that s/he be rejected from the medical staff membership (including the reason for rejection), or that his/her application be deferred for further consideration. The executive committee may request additional information, elect to interview the applicant and/or return the matter to a clinical department and/or the credentials committee. Any and all recommendations for appointment must also specifically state the clinical privileges to be granted which may be qualified by probationary conditions.

E. When the recommendation of the executive committee is to defer the application for further consideration, it must be followed up within ninety (90) days with a subsequent recommendation for provisional appointment with specified clinical privileges, or for rejection of medical staff membership.

F. When the recommendation of the executive committee is a favorable one, the chief executive officer shall promptly forward the application, to the governing board.

G. If the executive committee's recommendation is to deny the application for appointment to the medical staff or to deny any clinical privileges requested in the application, the executive committee shall include the reason for its recommendation.

1. Should the denial be for clinical privileges requested which are either outside of the scope of practice at this facility or under an exclusive contract, the applicant shall be so notified and shall not be accorded hearing rights. The applicant shall be notified of the adverse recommendation by mail.
2. Should denial of the application be for reasons other than those noted above, and if the denial is grounds for a hearing as provided in Article VIII of these bylaws, then a notice shall inform the applicant of his or her rights to a hearing to review the adverse recommendation pursuant to Article VIII of these bylaws.

H. If practical, at its next regular meeting after receipt of a favorable recommendation, the governing board shall act on the matter. If the governing board's decision is favorable to the practitioner, it shall be final and the chief executive officer shall send notice of the decision to the chief of the medical staff, the chief of the department concerned and shall notify the practitioner concerned. If the governing board's decision is adverse to the practitioner with respect to either appointment or clinical privileges, and if the adverse decision is grounds for a hearing, the chief executive officer shall promptly notify him/her of such adverse decision by mail, and such adverse decision shall be held in abeyance until the practitioner has exercised, or has been deemed to have waived, his/her rights under the medical staff hearing rights section of the bylaws. In making their recommendation, the governing board shall give great weight to the recommendation of the medical staff and shall not act arbitrarily or unreasonably.

I. Each step in the review process shall be completed as promptly as is reasonably possible in view of the duty to exercise due care in the review of the applicants. Whenever the chief of staff and chief executive officer agree that the review process has been unduly delayed at any particular step, they may jointly direct the review to be advanced to the next applicable step.

J. Any applicant who:

1. Has received a final adverse decision regarding appointment and/or privileges, or;
2. Withdrew his/her application or request for membership or privileges following an adverse recommendation by the executive committee or the governing board; **OR**

A member or former medical staff member who has:

1. Received a final adverse decision resulting in termination of medical staff membership/or clinical privileges, or;
2. Resigned from the medical staff while an investigation was pending, following issuance by the executive committee or governing body of a recommendation adverse to the member's medical staff membership and/or clinical privileges;

Shall not be eligible to reapply for the medical staff membership and/or the clinical privileges affected by the previous action for a period of at least two years from the date the adverse decision became final, the date the application or request was withdrawn, or the date that the former medical staff member's resignation became effective, whichever is applicable.

K. A decision or recommendation shall be considered adverse only if it is based on medical disciplinary cause or reason, unethical conduct, conduct which is disruptive to Hospital operations or the delivery of patient care, or failure to meet minimum professional standards. Actions which are not considered to be adverse for the purpose of this section include actions based on failure to maintain a practice in this area which can be cured by a move, failure to maintain appropriate amounts of malpractice insurance which can be cured by securing insurance, failure to complete medical records which can be cured by completing medical records, or failure to pay medical staff dues which can be cured by submission of a complete application and payment of an application fee. Further, for the purpose of this section, an adverse decision shall be considered final at the

time of completion of all hearing and appellate review proceedings as provided in medical staff bylaws provisions.

L. After the two- year_period, the former applicant or former medical staff member may submit an application for medical staff membership and/or clinical privileges which shall be processed as an initial application. The former applicant or former medical staff member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable.

M. Any practitioner who resigns or has been deemed to have voluntarily resigned from the medical staff who subsequently applies for medical staff membership or clinical privileges shall be processed as an initial applicant and will not be entitled to apply for appointment if s/he has any unfulfilled obligations under these bylaws or the rules and regulations, including, but not limited to, the need to complete medical records

N. Physicians who have resigned, been deemed voluntarily resigned, or who have been terminated must submit an initial application and pay an initial application fee.

O. Notwithstanding the terms and conditions of Article V, upon the approval of the department, the medical executive committee, and the governing board, a process may be established for expedited credentialing of applicants for appointment who meet specified criteria in accordance with the medical staff rules and regulations.

ARTICLE VI. REAPPOINTMENT PROCESS

A. Members of the medical staff shall be reappointed at least every two (2) years. At least 180 days prior to the expiration of the member's appointment, a member shall be sent a reappointment application by mail. The member must return the completed application within sixty (60) days of the date it was received in the practitioner's office.

Receipt of reapplication or requested information subsequent to the 60 days shall not be accepted. The practitioner would need to complete a new application packet, with application fees, in order to be processed as a new applicant. Privileges and membership would be maintained until such time as the original appointment expires. Should the new appointment request be completed prior to the time of expiration, membership and privileges will be maintained with the approval date being that of the newly approved application.

A practitioner who fails to return the form or to supply all of the required information within sixty (60) days, without good cause, shall be deemed to have resigned his/her medical staff membership, effective as of the date of the expiration of his/her current appointment. A practitioner who is deemed to have resigned under this section shall not be entitled to the hearing and appeal rights under these bylaws. A practitioner whose privileges and membership have been deemed to be voluntarily relinquished for failure to timely complete and submit the required application or failure to timely submit additional information required in order for the application to be deemed complete may petition to appear before the Medical Executive Committee for the sole purpose of establishing "good cause" for the failure to timely complete or the failure to timely submit the additional information requested in order for the application to be deemed complete. This shall not be deemed a hearing or give rise to other rights pursuant to these bylaws. The decision of the Medical Executive Committee shall be final.

The applicant shall have the burden of producing adequate information for a proper evaluation of his/her competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

The reappointment application shall be in writing, on a form prescribed by the executive committee, and it should require detailed information concerning the changes in the applicant's qualifications since last review. Information required on the reappointment application form shall include, but not be limited to, all of the information and certifications requested in the appointment application form, except the information regarding the members pre-medical and medical

education, internship, residency, and fellowship training (unless additional training has been undertaken since the time of last appointment), date of birth, etc. This form shall also require information as to whether the applicant requests any change in his/her staff status and/or clinical privileges, including any reduction, deletion or additional privileges. Requests for additional privileges must be supported by evidence of continuing medical education and or experience, type and nature of evidence, which would be necessary for such privileges to be granted in initial application for same. The medical staff member is required to submit reasonable evidence of current health status, if requested by the executive committee. The member shall supply malpractice/claims history during the last period of reappointment, which may include a detailed list from the practitioner as well as his/her malpractice carrier. The malpractice information shall be compared with information received from the National Practitioner Data Bank. The applicant shall be responsible for clearing up any discrepancies identified.

If the staff member's level of clinical activity at this hospital is not sufficient to permit the medical staff and governing board to evaluate his/her competence to exercise the clinical privileges requested in order for the application to be deemed complete, the staff member shall have the burden of providing evidence of clinical performance at his/her principle institution or from office records as directed by the Medical Staff office following consultation with the credentials committee chair, department chair, executive committee or governing board.

Neither the medical staff office, medical staff, nor governing board shall have any obligation to review a reappointment until it is complete in all respects and the applicant submits all required information and supporting material.

B. The medical staff shall, in timely fashion, seek to verify the additional information made available on each reappointment application form and to collect any other materials or information deemed pertinent by the credentials committee, executive committee or department chair. Such additional information shall address, without limitation:

1. Patterns of care and utilization as demonstrated in the findings of quality review, risk management, utilization management, clinical pertinence, and department activities;

2. Participation in relevant continuing education activities;

3. Nature and volume of clinical activity (patient care contacts) at the hospital or another hospital or healthcare facility if requested;

4. Corrective actions or disciplinary actions/issues;

5. Health status including completion of a physical examination or psychiatric evaluation to be completed by a physician who is mutually accepted by the affected practitioner and executive committee, when so requested by the executive committee;

6. Attendance at medical staff department and committee meetings, where required;

7. Timely and accurate completion and preparation of medical records;

8. Professional conduct in working with other practitioners, hospital personnel, patients in the hospital, and families;

9. Professional liability claims experience, including being named as a party in any professional liability claims and the disposition of any pending claims;

10. Compliance with all applicable hospital and medical staff bylaws, policies, rules and procedures;

11. Any other pertinent information including staff member's activities at other hospitals and his/her medical practice outside the hospital; and

12. Information concerning the member from the Medical Board of California and the National Practitioner Data Bank.

13. Information concerning the member relating to a Criminal Background Check.

Physicians requesting reappointment to the Medical Staff shall be required to obtain a peer recommendation from a physician who is familiar with their work and who is not currently financially associated with the applicant. Peer recommendation may be from another physician in the same clinical department.(1/05)

The medical staff office shall transmit the completed reappointment application form and supporting materials to the credentials committee, to the chair of the clinical department to which the staff member belongs and to the chair of any other department in which the member has or requests privileges.

C. The credentials committee shall meet at least quarterly to review the applications and all pertinent information available on each member who is being considered for reappointment and shall transmit it's recommendation(s) to the applicable department chair and executive committee.

D. The department chair shall review the application and the staff member's file and shall transmit to the executive committee his/her written report and recommendations.

E. The executive committee shall review the department chair and credentials committee reports, all other relevant information available to it, and shall forward to the governing body its favorable reports and recommendations.

F. The department chair, credentials committee and executive committee reports and recommendations shall be in writing and shall be submitted in the form prescribed by the executive committee. Each report and recommendation shall specify whether the applicant's appointment should be renewed, renewed with modified membership category, be conditionally reappointed (as defined in the rules and regulations), department affiliation, and/or clinical privileges, or terminated. Where non-reappointment, denial of requested privileges, a reduction in status, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated and documented.

G. Each recommendation concerning the reappointment of a medical staff member and the clinical privileges to be granted upon reappointment shall be based on whether such member has met the qualifications specified in these bylaws and rules and regulations.

Recommendations also shall be based upon the practitioner's compliance with legal requirements applicable to the practice of his/her profession, with the medical staff bylaws, rules and regulations and hospital policies, review and evaluation of the care provided by the practitioner, evaluation of interactions with hospital staff and peers, physical and/or mental impairment which might interfere with the applicant's ability to carry out clinical privileges as requested, and provision of accurate and complete information to enable the medical staff to evaluate his/her current competency and qualifications.

H. If the executive committee recommends adverse action, as defined in these bylaws, either in respect to reappointment or clinical privileges, the chief of staff shall give the applicant written notice of ~~the~~ adverse recommendation. If the adverse recommendation is grounds for a hearing, the notice also shall advise the applicant of his/her right to request a hearing in the manner specified in the Hearing and Appellate Review portion of these bylaws, and the applicant shall be entitled to procedural rights.

The governing body shall be informed of, but not take action on, the pending recommendation until the applicant has exhausted or waived his procedural rights.

Thereafter, the procedures specified in these bylaws, shall be followed. The executive committee may defer action; however, any such deferral must be followed up within 70 days.

I. If the executive committee recommendation is favorable to the practitioner but the governing board's decision is adverse to the practitioner with respect to either appointment or clinical

privileges, the chief executive officer shall promptly notify him/her of such adverse decision by "mail", as such term is defined in these bylaws, and such adverse decision shall be held in abeyance until the practitioner has exercised or has been deemed to have waived his/her rights under these bylaws. In making their recommendation under this section, the governing board shall give great weight to the recommendation of the medical staff and shall not act arbitrarily or unreasonably. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges when none existed before.

K. Submission of an application for reappointment signifies that the medical staff member has participated in a sufficient number of patient care activities at the hospital each year since the last period of reappointment in order to demonstrate current competence. Should the physician have insufficient activity at the hospital in order to demonstrate current competence, documentation must be submitted to support current competence from another facility where the physician is currently practicing or via office records. If the practitioner is unable to verify activity, by virtue of copies of H&P's, discharge summaries, operative reports, consultation reports or other documentation submitted and accepted by the credentials committee or department chair, within sixty (60) days of the request, such failure will be regarded as a voluntary resignation which will become effective on the date of expiration of his/her current appointment.

L. If a practitioner wishes to reapply following such a voluntary resignation, s/ he must submit a complete initial application and an application fee in order to be considered for appointment. Practitioners shall be processed as new applicants and have the burdens set forth in these bylaws of a new applicant.

M. A recommendation to reappoint shall not be deemed to be a waiver by the medical staff of its right to subsequently take corrective action or any other adverse action in accordance with these bylaws based upon the qualifications, conduct or other activity or information which may have existed or occurred prior to such appointment.

ARTICLE VII. CORRECTIVE ACTION

SECTION I. ROUTINE MONITORING AND EDUCATION

A. Responsibility

It shall be the responsibility of the chair of the clinical departments, who may work through or with the assistance of a standing department, committee, or an ad hoc committee to:

1. Monitor and assess the quality of professional practice in each department
2. Promote high quality of practice in each department by:
   a. Providing education and counseling, and
   b. Issuing letters of admonition, warning, censure, as necessary and,
   c. Requiring routine monitoring when deemed appropriate

B. Procedure

1. Review and Studies: Each department shall conduct regular patient care reviews and studies of practice within the department in conformity with the hospital's general performance improvement plan (Plan for Provision of Care) and department plan. The department chair, working through committees, as appropriate, may review any matter or practitioner which has been brought to its attention which relates to the professional practice in the department.

2. Informal Counseling: In order to assist department members in conforming their conduct or professional practice to the standards of the medical staff and hospital, the department chair may issue informal comments and/or suggestions, either orally or in writing. Such comments or suggestions shall be subject to the confidentiality requirements of all medical staff information and may be issued by the department chair with or without prior discussion with the recipient and with or without consultation with the department. Such comments or suggestions shall not constitute a restriction of privileges, shall not be considered to be corrective action, and shall not give rise to hearing, review or appeal rights. Such actions taken need not be reported to the medical executive committee. Written

documentation of the counseling shall be placed in the practitioner's permanent credentials file.

3. Following discussion of identified concern(s) with any department member, any department may authorize the chair to issue a letter of admonition, warning, censure, or to require such member to be subject to routine monitoring for a stipulated period of time. Such action may also be initiated by the department chair in concurrence with the chief of staff without the authorization of the department. The affected member may make a written response, which shall be placed in the member's credential file. The discussions of such actions with the individual members shall be informal. Such action shall not constitute a restriction of privileges, shall not be considered to be corrective action, and shall not give rise to a hearing review or appeal rights. Matters, which require monitoring, shall be reported to the medical executive committee at the next regular meeting. All other routine monitoring shall not require reporting to the medical executive committee.

4. Should an issue relating to a member of the medical staff be reviewed by a department, division, or committee of the medical staff, the chair shall afford the member the ability to provide information pertaining to the issue if the member is in attendance at the meeting. Once this has been done, the member shall be asked to leave the meeting in order to allow for candid discussion and to preserve the confidentiality of the peer review process. Should the chair deem that the issue is not one which would warrant such exclusion from the meeting, the member shall be allowed to remain.

SECTION 2. CORRECTIVE ACTION

A. Any person may provide information to the hospital or medical staff about the conduct, performance, or competence of any member. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be:

1. Detrimental to patient safety or to the delivery of quality patient care within the hospital;
2. Unethical;
3. Contrary to the medical staff or hospital bylaws, rules and regulations, standards or policies and procedures; or
4. Below applicable medical staff or hospital professional standards;
5. Disruptive to the functioning of the hospital or interfering with the provision of quality patient care;
6. Conduct which is reported as harassing, abusive, or discriminatory to hospital staff, other members of the medical staff, patients and/or families.

A request for an investigation or corrective action against such member may be requested by any member of the medical staff or the governing board, or the chief executive. All requests for corrective actions shall be in writing, shall be made to the executive committee, and shall be supported by reference to the specific activities or conduct which constitute the grounds for request.

B. If the medical executive committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The medical executive committee may conduct the investigation itself, or may assign the task to an appropriate medical staff officer, medical staff department, or standing or ad hoc committee of the medical staff. The medical executive committee, at its discretion, may appoint practitioners who are not members of the medical staff as temporary members of the medical staff for the sole purpose of serving on a standing or ad hoc committee.

C. The officer, department or committee designated to perform the investigation, shall promptly investigate and make a report of its investigation to the executive committee. Prior to making the report, the practitioner against whom corrective action has been requested shall have an opportunity for an interview with the investigating person or committee. At such interview, s/he shall be informed of the general nature of the charges against him/her and shall be invited to discuss, explain, or refute them. This interview shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in these bylaws with respect to a hearing

shall apply. A record of such interview shall be made by the officer, department or committee performing the investigation and included with its report to the executive committee.

D. The medical executive committee may at any time within its discretion take whatever action may be warranted by the circumstances including summary suspension or termination of the investigative process.

E. As soon as practicable after conclusion of the investigation, the medical executive committee shall take action upon the request. If the corrective action could involve a reduction or suspension of clinical privileges, or a suspension or expulsion from the staff, the affected practitioner shall be permitted to make an appearance before the executive committee prior to its taking action on such request. This appearance shall not constitute a hearing, shall be preliminary in nature, and none of the procedural rules provided in the bylaws with respect to hearings shall apply thereto. A record of such appearance shall be made by the executive committee.

F. Actions which the medical executive committee may recommend shall include, without limitation:

1. Determining no corrective action should be taken;
2. Deferring action for a reasonable time not to exceed ninety (90) days where circumstances warrant;
3. Issuing a letter of warning, admonition, reprimand, or censure, although nothing herein shall be deemed to preclude medical staff, department or committee chairs, from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
4. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;
5. Recommending reduction, modification, suspension or revocation of clinical privileges;
6. Recommending reduction of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
7. Recommending suspension, revocation, or probation of medical staff membership; or
8. Taking other actions deemed appropriate under the circumstances.

G. The chair of the medical executive committee shall promptly notify the chief executive officer, , of all requests for corrective action received by the executive committee and shall continue to keep the chief executive officer fully informed of all action taken in connection therewith. If the executive committee recommends any corrective action which would entitle the practitioner to request a hearing pursuant to the Hearing and Appellate Review Procedure, the executive committee shall give the practitioner written notice of its recommendation. Unless the executive committee has decided to impose a summary suspension or limitation of the practitioner's privileges as provided or under Summary Suspension, the executive committee's recommended action shall not go into effect until the practitioner has either completed or waived any applicable hearing, review or appeal rights provided in the Hearing and Appellate Review Procedure. Any executive committee action, which has become effective shall remain in effect until it expires according to its own terms or is modified or terminated.

H. If the executive committee does not recommend any corrective action, which would entitle the practitioner to a hearing, the executive committee shall transmit its recommendation together with a report of its investigation to the governing board. The governing board may adopt the executive committee recommendation, in which case the recommendation shall become final. The governing board may elect to remand the matter to the executive committee for further review and recommendation, to investigate the matter further or to recommend different corrective actions, provided that the governing board shall give great weight to the executive committee's recommendation and shall initiate further action only if the failure to recommend action is contrary to the weight of the evidence before the governing board and only after the governing board has consulted with the executive committee and the executive committee has failed to take prompt action which the governing board determines is consistent with the weight of the evidence. If the governing board recommends action, which would entitle the practitioner to a hearing, the governing board shall give the practitioner written notice.

SECTION 3. SUMMARY SUSPENSION

A. Whenever the failure to immediately suspend or restrict a practitioner's clinical privileges may result in an imminent danger to the health, safety, or well-being of any individual, any or all of the practitioner's clinical privileges may be summarily suspended or restricted effective immediately upon imposition by:

1. Either the chief of staff, the medical executive committee, chair of the department in which the practitioner holds clinical privileges, or any one of their designees or
2. The chief executive officer following consultation with the chief of staff or the chair of the department in which the practitioner holds clinical privileges or either of their designees, unless the chief executive officer shall determine that there is insufficient time available for consultation. The person suspending a practitioner summarily shall notify the chief of staff or designee and chief executive officer or designee within twenty-four (24) hours of suspending the practitioner.
3. When no person or committee referenced in Article III, Section 3A, 1 or 2, is available to impose a summary suspension or restrict clinical privileges, the governing board or its designee may take such action if failure to do so may result in an imminent danger to the health of any individual, provided the governing board has, before the suspension, made reasonable attempts to contact the chief of staff or his/her designee. A suspension by the governing board which has not been ratified by the chief of staff or his designee, within two (2) working days, excluding weekends and holidays, shall terminate automatically without prejudice to further summary action as warranted by the circumstances.

B. Such summary suspension shall become effective immediately upon imposition. The person or body responsible therefore shall immediately give oral notice of the suspension to the practitioner and shall promptly within no more than five (5) days give written notice of the suspension to the practitioner and the executive committee. The notice to the practitioner shall be deemed to have occurred on the earlier of the dates the practitioner was notified, orally or in writing. The oral notice or written confirmation should inform the practitioner of his right to request the executive committee to review the suspension under Section C. of this Article. The notice of the suspension given to the executive committee shall constitute a request for corrective action. Following such notice, the executive committee shall complete its corrective action investigation and shall make its corrective action recommendation and report within thirty (30) days following the notice of summary suspension.

A practitioner whose clinical privileges have been summarily suspended and who has requested an interview within seven (7) days after s/he was notified of the suspension may be informally interviewed by the executive committee within such reasonable time period thereafter as the executive committee may be convened, not to exceed fourteen (14) after notice of suspension was given. This interview shall be informal and shall not constitute a hearing or review as provided in the Hearing and Appellate Review Procedure.

C. The medical executive committee may recommend modification, continuance or termination of the terms of the summary suspension. If the medical executive committee does not terminate the summary suspension after the suspension has been in effect in excess of fourteen (14) days, the medical executive committee shall give the practitioner written notice of his right to request a hearing pursuant to the Hearing and Appellate Review Procedure. If the practitioner does request a hearing in a timely manner, the suspension shall remain in effect until the hearing and appeal are completed. In that case, the executive committee also shall complete its corrective action investigation and give prompt notice of its recommendation in order to assure that the hearing to review the summary suspension is combined with any hearing or review to which the practitioner may be entitled because of the executive committee's corrective action recommendation.

D. Immediately upon the imposition of a summary suspension, the chief of staff or responsible chair of department or designee shall have authority and responsibility to provide for alternative medical coverage for the patients of the suspended practitioner still in the hospital at the time of

suspension. The wishes of the patients shall be considered in the selection of such alternative practitioner.

SECTION 4. AUTOMATIC SUSPENSION, RESIGNATION AND TERMINATION

A. Automatic suspension will be imposed if one or more of the following occurs.

1. For failure to maintain current and valid California licensure
2. For failure to provide proof that the practitioner maintains a current DEA certificate with a full schedule (with the exception of clinical psychologists, pathologists, and telemedicine physicians and non-admitting category physicians).
3. Failure to provide adequate proof that the practitioner has maintained malpractice insurance as required by the bylaws and by the governing board.
4. Failure to pay medical staff dues in accordance with these bylaws
5. Failure, without good cause, to appear and satisfy the special meeting attendance requirements set forth under Article XIII, Section 5, shall automatically be suspended from exercising all or such portion of his/her clinical privileges as the executive committee may direct

It shall be the duty of the chief of staff to cooperate with the chief executive officer in enforcing all automatic suspensions. Failure to correct the deficiency which was the basis for the automatic suspension within ninety consecutive days (90 days) after the date a suspension became effective shall be deemed a voluntary resignation of the practitioner's medical staff membership and clinical privileges. Practitioners whose clinical privileges are automatically suspended and/or have resigned their medical staff membership and/or clinical privileges pursuant to the above, shall not be entitled to the procedural rights set forth in the Hearing and Appellate Review Procedure.

Medical record suspensions and deemed resignations shall be imposed in accordance with the Medical Staff rules and regulations and Hospital policy.

SECTION 5. AUTOMATIC RETRACTIONS AND TERMINATIONS

The following may be grounds for automatic termination of privileges without hearing rights:

1. Revocation or suspension of a practitioner's license shall result in automatic termination of the practitioner's Medical Staff membership and clinical privileges.
2. Expiration of the member's license shall result in the automatic suspension of the practitioner's privileges. If the license is not retroactively reinstated with 60 days after its expiration, the practitioner will be deemed to have voluntarily resigned.
3. If the practitioner's professional license is placed on probation, is restricted or limited, then the same terms of probation, restrictions or limitations automatically shall be placed on the practitioner's privileges and the foregoing may be deemed a request for corrective action against such practitioner.
4. If restrictions or terms of probation are placed on a practitioner's right to prescribe, such conditions, terms and restrictions automatically shall be placed on the practitioner's right to prescribe and may be deemed a request for corrective action against such practitioner.
5. Conviction, pleading guilty or no contest to a felony

ARTICLE VIII. HEARING AND APPELLATE REVIEW PROCEDURE

SECTION 1. HEARING REQUIREMENTS

The hearing requirements set forth in this Fair Hearing Plan are applicable to physicians, oral surgeons, dentists, psychologists, and podiatrists who are applying to be members or are members of the Medical Staff. Fair Hearing and Appellate Review Procedures for allied health professionals are located in the, allied health professional's section of these bylaws.

SECTION 2. INITIATION OF HEARING

A. Recommendations or Actions: The following recommendations or actions shall, if deemed adverse pursuant to Section 2.B of this Plan, and if based upon MDCR_entitle the practitioner affected thereby to a hearing:

1. Denial of initial staff appointment
2. Denial of reappointment
3. Suspension of staff membership
4. Revocation of staff membership
5. Denial of requested advancement in staff category
6. Reduction in staff category
7. Denial of requested clinical privileges
8. Reduction in clinical privileges
9. Suspension of clinical privileges
10. Revocation of clinical privileges
11. Restrictions imposed on clinical privileges

B. When deemed Adverse: A recommendation or action listed in Section 2.a of this Plan shall be deemed adverse only when it has been:

1. Recommended by the medical executive committee; or
2. Taken by the governing board contrary to a favorable recommendation by the medical executive committee; or
3. Taken by the governing board on its own initiative without benefit of a prior recommendation by the medical executive committee.

C. Notice of Adverse Recommendation or Action: A practitioner against whom an adverse recommendation or action, as described in Section 2A, has been taken pursuant to Section 2.B shall promptly be given notice of such action in accordance with section 10.D . Such notice shall:

1. State that an adverse professional review action has been proposed to be taken against the practitioner. If the action must be reported to the Medical Board of California pursuant to Section 805 of the California Business and Professions Code should it be adopted, the notice shall so advise the practitioner.
2. State what adverse action has been proposed. Inform the practitioner that if the recommendation or final proposed action adversely affects the practitioner's clinical privileges for a period of longer than 30 days and is based on competence or professional conduct, that the action if adopted will be reported to the National Practitioner Data Bank.
3. State what adverse action has been proposed including a brief statement of the reasons for the proposed action.
4. Advise the practitioner of his/her rights to request a hearing pursuant to the provisions of the medical staff bylaws and the Fair Hearing Plan.
5. Inform the practitioner that s/he has thirty (30) days following the date of receipt of notice within which to request a hearing.
6. State that failure to request a hearing within a specified time period shall constitute a waiver of rights to a hearing and to an appellate review on the matter.
7. Inform the practitioner that s/he has the hearing rights described in Article XIII of the medical staff bylaws.

D. Request for a Hearing: A practitioner shall have thirty (30) days following his/her receipt of a notice pursuant to Section 2.C. to file a written request for a hearing. Such request shall be delivered to the chief executive officer either in person with receipted delivery, by receipted delivery service or by certified or registered US mail, return receipt requested.

E. Waiver by Failure to Request a Hearing. A practitioner who fails to request a hearing within the time and in the manner specified in Section 2.D waives any right to such a hearing and to any appellate review to which s/he might otherwise have been entitled. Such waiver in connection with:

1. An adverse action by the governing board shall constitute acceptance of that action which shall thereupon become effective as the final decision by the governing board.
2. An adverse recommendation by the medical executive committee shall constitute acceptance of that recommendation, which shall thereupon become and remain

effective pending the final decision of the governing board. The governing board shall consider the medical executive committee's recommendation at its next regular meeting following the waiver. In its deliberation, the governing board shall review all relevant information and material considered by the medical executive committee and may consider all other relevant information received from any source. The governing board shall give great weight to the medical executive committee's recommendation, and in no event shall act in an arbitrary or capricious manner. If the governing board's action on the matter is not in accord with the medical executive committee's recommendation, the matter shall be submitted to a joint conference which consists of an equal number of medical staff members appointed by the chief of staff and governing board members appointed by the chair of the governing board. The joint conference shall meet and make a recommendation to the governing board within thirty (30) days of submission of a matter to it. The governing board's action on the matter following receipt of the joint conference recommendation shall constitute its final decision. The chief executive officer shall promptly notify the practitioner of action taken pursuant to this Section 2.E 2. and shall notify the chief of staff and the medical executive committee of each such action.

SECTION 3. HEARING PREREQUISITES

A. Notice of Time and Place for Hearing: Upon receipt of a timely request for hearing, the chief executive officer shall deliver such request to the chief of staff, and if the governing board action prompted the request for the hearing, to the governing board. At least 30 days prior to the hearing, the chief of staff or his designee shall send the practitioner notice of the time, place and date of the hearing in accordance with Section 10.D. hereof. The hearing date shall be not less than 30 days from the date the notice of the hearing is mailed to the practitioner, nor more than 60 days from the date of receipt of the request for hearing.

B. Statement of Issues and Events: The notice of hearing required by Section 3.A shall contain a concise statement of the practitioner's alleged acts or omissions, a list by number of the specific or representative patient records in question and/or the other reasons or subject matter forming the basis for the adverse recommendation or action which is the subject of the hearing.

Amendments to the statement of issues and events may be made at any time prior to the close of the hearing by the medial staff representative at the hearing. Such amendments may delete, modify, or add to the acts, omissions, charts or reasons specified in the original notice. Notice of amendments shall be given to the affected practitioner and the Hearing Officer. In the event the amendment to the notice reasonably causes the practitioner to need additional time to prepare and respond, the Hearing Officer shall grant a reasonable postponement of the hearing to enable the practitioner to prepare a response or defense to any such amendment that substantially adds to, or modifies the acts which are the basis for the hearing.

C. Appointment of Hearing Committee or Arbitrator: The hearing shall be held before a trier of fact which shall be a Hearing Committee composed of not less than 5 individuals. The chief of staff shall appoint the Hearing committee if the medical executive committee initiated the action and the chief executive officer shall appoint the Hearing Committee if the board initiated the action. The panel shall be composed of individuals who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, fact finder, or initial decision maker in the same matter, and shall include, where feasible, an individual practicing the same specialty as the practitioner;

D. Appointment of hearing officer: A hearing officer shall be appointed to preside at the evidentiary hearing. The appointment of such an officer shall be determined by the chief of staff if the medical executive committee initiated the action and by the chief executive officer if the board initiated the action. A hearing officer may or may not be an attorney at law, but must be experienced in conducting hearings. The hearing officer shall act as the presiding officer of the hearing. The individual selected shall gain no direct financial benefit from the outcome, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

E. Questioning Panel Members: Both sides shall have the right to question panel members and the hearing officer regarding their qualifications and/or impartiality.

F. Challenges: Both sides shall have the right to challenge the impartiality of any panel member or hearing officer. Such challenges shall be ruled on by the hearing officer whose decision shall be final.

G. Inspecting Documentary Information: Each party shall have the right to inspect and copy, at its own expense, documentary information relevant to the charges which the other party has in its possession or control as soon as practicable after a receipt of a request therefore, but at least thirty (30) days prior to the hearing if reasonably possible. The right does not extend to confidential information referring solely to other practitioners rather than to the practitioner under review. Any dispute regarding requests for access to information shall be submitted in writing to the hearing officer, who shall consider and rule upon the request and who may impose any safeguards deemed necessary in the interests and fairness or for the protection of the peer review process. When ruling on the request and determining the relevancy of the information being sought, the hearing officer shall consider:

1. Whether the information may be introduced to support or defend the charges;
2. The exculpatory or inculpatory nature of the information sought, if any;
3. The burden imposed on the party in possession of the information, if access is granted; and
4. Any previous request for access to information submitted or resisted by the parties to the same proceeding.

H. Documents and Witnesses To Be Produced at Hearing: At the request of either side, the parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. This exchange shall take place at least 10 days prior to commencement of the hearing. The witness list shall be amended when additional witnesses are identified.

I. Continuances: A continuance may be granted based upon a showing of good cause which shall include, but not be limited to:
1. The failure of either party, following approval of the request by the hearing officer, to provide access to requested information at least 30 days prior to the hearing.
2. The failure of either party to provide a requested list of witnesses or copies of all documents expected to be introduced at the hearing at least 10 days prior to the hearing.
3. The mutual agreement of the parties.

J. Prehearing Procedure: It shall be the duty of practitioner and the body whose decision prompted the hearing to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural irregularity or any objection to the hearing panel or to the hearing officer, as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may expeditiously be made. Objection to any such pre-hearing decisions shall be raised at the judicial hearing and when so raised shall be preserved for consideration at any appellate review hearing which thereafter might be requested.

SECTION 4. HEARING PROCEDURE

A. Personal Presence: The personal presence of the practitioner who requested the hearing shall be required. Personal presence in and of itself does not fulfill the criteria for proceeding. A practitioner who fails without good cause to appear and proceed at such hearing shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 2.E. If the hearing has commenced, the Hearing Officer shall decide, in consultation with the Hearing Committee, whether a practitioner has failed without good cause to appear and proceed and should be deemed to have waived his or her rights. If the hearing has not commenced, the Hearing Officer shall make the foregoing decision.

B. Presiding Officer: The hearing officer shall act to maintain decorum and to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence. He/she shall be entitled to determine the order of procedure during the hearing and shall make all rulings on matters of procedure and the admissibility of evidence.

C. Representation: The hearings provided for in these bylaws are for the purpose of intra professional resolution of matters bearing on conduct or professional competency. Accordingly, neither the petitioner, the executive committee nor the governing board shall be represented, by legal counsel, before the Hearing Committee unless the Board, in its sole discretion, permits all sides to be represented by legal counsel. Any request for legal counsel must be made at the time the hearing request is made. The practitioner who requested the hearing shall be entitled to be accompanied and represented at the hearing by a licensed practitioner who is not an attorney-at-law and who preferably is a member of hospital's medical staff. The medical executive committee or the governing board, depending on whose recommendation or action prompted the hearing, shall appoint an individual to present the facts in support of the adverse recommendation or action, and to examine witnesses. A representative may also be a witness. The foregoing shall not be deemed to deprive the practitioner, the medical executive committee, or the governing board of the right to legal counsel in connection with preparation for a hearing or appellate review.

D. Rights of Parties: During the hearing, each of the parties shall have the right to:

1. Be provided with all information made available to the hearing panel.
2. Call, examine and cross-examine witnesses.
3. Present and rebut any evidence determined by the Hearing Officer to be relevant.
4. Submit a written statement at the close of the hearing.

If the practitioner who requested the hearing does not testify in his/her own behalf, s/ he may be called and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

E. Procedure and Evidence: The hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be admitted, regardless of the admissibility of such evidence in a court of law. Each party shall, prior to or during the hearing, be entitled to submit motions concerning any issue of law or fact. The moving party shall provide a copy of the motion to the other party who shall have five (5) working days to submit a written response to the Hearing Officer and the moving party. Such motions and response shall become part of the hearing record. The hearing officer may set guidelines for the introduction of evidence and testimony, and set time limits for each party's presentations, in order to conduct and conclude the hearing in a reasonable period of time given the circumstances. The hearing officer may set guidelines for the introduction of evidence and the hearing in order to conduct the hearing in a reasonable period of time given the circumstances. The body whose decision prompted the hearing may object to the introduction of evidence that was not provided by the practitioner during an appointment, reappointment or privilege application or corrective action despite requests for such action. The information shall be barred from the hearing by the hearing officer unless the practitioner can prove he previously acted diligently and could not have submitted the information.

Latitude may be exercised in accommodating the schedule of witnesses, hearing committee members, parties and representatives, and allowing modification of required notices, allowing recesses or extensions of time upon a reasonable showing of need, and allowing changes in the order of the proceedings and the presentation of evidence. The decision of the Hearing Officer, in consultation with the Hearing Committee regarding such matters shall be final, subject to later reconsideration for good cause only.

F. Official Notice: In reaching a decision, the Hearing Committee may take official notice, either before or after submitting the matter for decision, of any generally accepted matter, including but not limited to technical or scientific matter relating to the issues under consideration. Parties present at the hearing shall be informed of the matter to be noticed and be given the opportunity to refute the officially noticed matter by evidence or by written or oral presentation of authority; the manner of such refutation to be determined by the hearing committee. The committee shall also be entitled to consider all other information that can be considered, pursuant to the medical staff bylaws, in connection with applications for appointment or reappointment to the medical staff and for clinical privileges.

G. Burden of Proof

1. Duty of Producing Evidence: The medical executive committee shall have the initial duty to present evidence which supports the charge or recommended action.

2. Initial Applicants: When a hearing relates to Section 2.A, 1, 5 or 7, the practitioner who requests the hearing shall have the burden of proving his/her qualifications, by a preponderance of the evidence, by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for staff privileges or membership.

3. Current Staff Members: In all other cases, the medical executive committee or Board shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that the action or recommendation is reasonable and warranted.

H. Record of Hearing: A court reporter shall be used to make a record of the hearing. Each party shall be entitled to obtain a copy of the record thereof upon the payment of reasonable cost of preparation.

I. Postponement: Requests for postponement of a hearing after it already has commenced shall be granted by the hearing officer only upon showing of good cause and only if the request therefore is made as soon as it is reasonably practical. Requests for a continuance, prior to commencement of the hearing, are subject to Section 3.

J. Presence of Hearing Committee Members and Vote: A majority of the Hearing Committee must be present throughout the hearing and deliberations. If a committee member is absent from any part of the proceedings, s/he shall not be permitted to participate in the deliberations or the decision. The final decision of the Hearing Committee must be approved by a majority of the members who participated in the deliberations and decision.

K. Recesses and Adjournment: The Hearing Committee may recess the hearing and reconvene without additional notice for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon the conclusion of the presentation of oral and written evidence, the hearing shall be closed. The Hearing Committee shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the hearing shall be declared finally adjourned. If requested by the Hearing Committee, the hearing officer may be present during the deliberations, may be legal advisor to the hearing committee, and may assist in the drafting of the committee's written report and recommendation required pursuant to Section 5a hereof. However, the hearing officer shall not be entitled to vote.

L. Exclusion: No person shall disrupt any hearing. Any person in attendance who disrupts a hearing after being warned by the Hearing Officer to cease such disruption on penalty of exclusion, shall, at the discretion of the Hearing Officer, leave the hearing. If such excluded person is the affected practitioner or a witness, s/he shall have the right to submit to the Hearing Committee, not later than ten days after such exclusion, a written affidavit of his/her testimony or other evidence, with copies thereof to the other party.

M. Attendance Except as otherwise provided in these bylaws and subject to reasonable restriction by the Hearing Officer, the following individuals are permitted to attend the entire hearing: the Hearing Committee, the Hearing Officer, the court reporter, the practitioner, a representative of the body which initiated the adverse recommendation or action, one key consultant for each party, the chief executive officer or his/her designee, and the medical staff director or assistant.

Section 5. Hearing Committee Report and Further Action

A. Hearing Committee Report: As soon as reasonably possible after final adjournment of the hearing, the Hearing Committee shall make a written report of its findings and recommendation in the matter. The written report shall include the Committee's findings of facts and conclusions articulating the connection between the evidence produced at the hearing and the decision reached. If requested by the Hearing Committee, the Hearing Officer may assist the Hearing

Committee with the drafting of the written report. The report shall be forwarded, together with the hearing record and all other documentation considered by it, to the chief executive officer.

B. Notice: The chief executive officer shall promptly send a copy of the hearing committee's written report to the practitioner, to the chief of staff, to the medical executive committee and to the governing board.

Section 6. Initiation and Prerequisites of Appellate Review

A. Request for Appellate Review: Either the practitioner, or the medical executive committee or the governing board, depending on which body initiated the adverse recommendation or decision, shall have fourteen (14) days following its receipt of the Hearing Committee written report sent pursuant to Section 5.B to file a written request for an appellate review. The written request for an appeal shall include identification of the grounds for appeal and a clear and concise statement of facts in support of the appeal. The grounds for appeal from the hearing shall be 1) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; and/or 2) the decision was not supported by the evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.D. Such request shall be delivered to the chief executive officer either in person by receipted delivery or by certified or registered US mail return receipt requested and may, subject to tender of payment therefore, include a request for a copy record of the hearing committee and all other material, favorable or unfavorable not previously received, that was considered in making the adverse action or result.

B. Waiver by Failure to Request Appellate Review: A party which fails to request an appellate review within the time and in the manner specified in Section 6.A. above waives any right to such review. Such waiver shall have the same force and effect as that provided in Section 2E. of the Plan.

C Notice of Time and Place for Appellate Review: Upon receipt of a timely request for appellate review, the chief executive officer shall deliver such request to the governing board. As soon as practicable, the chair of the governing board shall schedule and arrange for an appellate review which shall be not less than 60 days no more than 90 days from the date of receipt of the appellate review request. At least eighteen (18) days prior to the appellate review, the chief executive officer shall send each of the parties special notice of the time, place and date of the review. The notice shall advise each party of its right to appear and respond at the appellate review and of its right to be represented by an attorney or any other representative of its choice. The time for the appellate review may be extended by the appellate review body for good cause and if the request therefore is made as soon as it is reasonably practical.

D. Appellate Review Body: The chair of the governing board shall determine whether the appellate review shall be conducted by the governing board as a whole or by an appellate review committee of 3 or more members of the governing board appointed by the chair of the governing board. Knowledge of the matter involved shall not preclude any member from serving as a member of the appeal board so long as that person did not participate in the matter at a previous level (e.g., as an accuser, investigator, fact-finder or initial decision maker). For purposes of this section, participating in an initial decision to recommend an investigation shall not be deemed to constitute participation in a prior hearing on the same matter. The appeal board may select an attorney to advise the governing board regarding its duties and to assist the governing board in drafting its final decision. If a committee is appointed, one of its members shall be designated as chair.

Section 7. Appellate Review Procedure

A. Nature of Proceedings: The proceedings by the review body shall be in the nature of an appellate review based upon the record of the hearing before the hearing committee and that committee's report. The governing board shall give great weight to the decision of the hearing committee and shall not act in an arbitrary or capricious manner. The governing board, however, shall exercise its independent judgment in determining whether a fair hearing was afforded, whether the decision was reasonable based upon the evidence considered by the hearing committee or such additional evidence as may be permitted pursuant to section 7D. Each party shall have the right to submit a written brief in support of its position. The party requesting the

appeal shall deliver a copy of its statement to the other party and the governing board at least fourteen (14) days before the Appellate Review. A written statement in reply may be submitted, and if submitted, a copy thereof shall be provided to the other party at least 2 days prior to the scheduled date of the appellate review.

B. Presiding Officer: The Chair of the Appellate Review Body shall be presiding officer, unless the chair of the governing board has appointed a Hearing Officer. The Presiding Officer shall determine the order of procedure during the review, make all required rulings, and maintain decorum. If a Hearing Officer is appointed, the Hearing Officer may act as an advisor, participate in the deliberations, and assist in the preparation of the decision, but shall not vote.

C. Oral Statement: Any party or representative appearing before the Appellate Review Body to present an oral statement shall be required to answer questions put to him/her by any member of the Appellate Review Body.

D. Consideration of New or Additional Matters: New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only in the discretion of the Appellate Review Body, and only following a determination by the Appellate Review Body that the party requesting consideration of such new or additional matter or evidence can demonstrate it previously acted diligently but could not have submitted such matter or evidence at the evidentiary hearing. A request to submit additional evidence shall be submitted to the Chair of the Appellate Review not less than fourteen (14) days prior to the Appellate Review. A written reply may be submitted, and if submitted, it shall be not less than two (2) days before the hearing. The Presiding Officer shall give notice of his/her decision on such matter to all parties as soon as reasonably possible.

E. Powers: The Appellate Review Body shall have all the powers granted to the hearing committee, and such additional powers as are reasonably appropriate to the discharge of its responsibilities.

F. Presence of Members and Vote: A majority of the Appellate Review Body must be present throughout the review and deliberations. If a member of the Review Body is absent from any part of the proceedings, s/he shall not be permitted to participate in the deliberations of the decision.

G. Recesses and Adjournment: The Appellate Review Body may recess the review proceedings and reconvene the same without additional notice for the convenience of the participants or to obtain new or additional evidence or a consultation. Upon the conclusion of oral statements, the appellate review shall be closed. The Appellate Review Body shall thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon the conclusions of those deliberations, the appellate review shall be declared finally adjourned.

H Action Taken: The Appellate Review Body may recommend that the governing board affirm, modify or reverse the recommendation of the Hearing Committee, or, in its discretion, may refer the matter back to the hearing committee for further review and recommendation to be returned to it within 60 days and in accordance with its instruction. Within 30 days after receipt of such recommendations after referral, the Appellate Review Body shall make its recommendation to the governing board provided in this Section 7.I.

I. Conclusion: The appellate review shall not be deemed to be concluded until all of the procedural steps provided herein have been completed or waived.

Section 8. Final Decision of the Governing Board

Within thirty (30) days after the conclusion of the appellate review, the governing board shall render its final decision in the matter in writing, shall include a statement of the governing board's basis for its decision, and shall include the text of the report which shall be made to the National Practitioner Data Bank, if any, and shall send notice thereof to the practitioner, to the chief of staff, and to the medical executive committee. The governing board's action on the matter shall be effective and final.

Section 9. National Practitioner Data Bank Reporting

A. Adverse Actions: The authorized representative shall report an adverse action to the National Practitioner Data Bank in accordance with the rules and regulations promulgated thereunder. The

authorized representative shall report any and all revisions of an adverse action including, but not limited to, any expiration of the final action consistent with the terms of that final action.

B. Dispute Process: A member who was the subject of an adverse action report may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the chief of staff, the chair of the subject's department, and the chief executive officer, or their respective designees.

Section 10. General Provisions

A. Number of Hearings and Reviews: Notwithstanding any other provision of the medical staff bylaws or of this Plan, no practitioner shall be entitled as a right to more than one evidentiary hearing and appellate review with respect to an adverse recommendation or action.

B. Release: By requesting a hearing or appellate review under this Fair Hearing Plan, a practitioner agrees to be bound by the provisions regarding immunity from liability in all matters relating thereto.

C. Waiver: If at any time after receipt of notice of an adverse recommendation, action or result, a practitioner fails to make a required request or appearance or otherwise fails to comply with this Fair Hearing Plan or to proceed with the matter, s/he shall be deemed to have consented to such adverse recommendation, action or result and to have voluntarily waived all rights to which he might otherwise have been entitled under the medical staff bylaws then in effect or under this Fair Hearing Plan with respect to the matter involved.

D. Notice: Any and all notices required hereunder shall be delivered personally to the addressee with receipted delivery, sent by receipted delivery, or by prepaid registered or US certified mail, return receipt requested. The notice shall be deemed received upon its actual delivery if personally delivered or delivered by receipted delivery.

E. Substantial Compliance: Technical non-prejudicial or insubstantial deviations from the procedures set forth in these bylaws shall not be grounds for invalidating the action taken.

Section 11. Exceptions to Hearing Rights

A. Termination of Temporary Privileges: No practitioner is entitled to the hearing, review or appeal rights provided in this Article VIII by virtue of the expiration, non-renewal or termination of temporary clinical privileges, unless such action is expressly stated to be for a medical disciplinary cause.

B. Closed Staff or Exclusive Use Departments, Hospital Contract Physicians:

(I) Closed Staff or Exclusive Use Departments. The fair hearing rights of this Article do not apply to a practitioner whose application for medical staff membership and privileges was denied or whose privileges were terminated or limited because the privileges s/he seeks or held are subject to a closed staff or exclusive use policy.

(ii) Practitioners who serve as hospital contract physicians are not entitled to the fair hearing rights of this Article to review the termination or expiration of their contracts. Termination of such contracts shall not affect such practitioners' medical staff membership or privileges, although the right of access to hospital equipment, resources and personnel reasonably necessary to exercise those privileges may be restricted or denied if and when the Hospital enters into an agreement which grants another practitioner or medical group the exclusive right to provide some or all of the services which encompass the practitioners' clinical privileges. Notwithstanding the foregoing, the hearing rights of this Article shall apply to the extent that an action is taken which must be reported under Business and Professions Code Section 805 and to the extent that medical staff membership status or clinical privileges which are independent of the practitioner's contract and not subject to an exclusive contract are removed or suspended.

C. Allied Health Professionals. Allied health professionals are not entitled to the rights set forth in this Article.

D. Denial of Applications for failure to Meet Minimum Qualifications. A practitioner shall not be entitled to a hearing or appellate review if his or her membership application or privileges request is denied because of his or her failure to submit documents or information required by the Medical Staff during the course of the credentialing process or specified on the application for appointment or reappointment.

E. Automatic Suspensions and Resignations. Subject to the terms of Article VII, Section 4; Practitioners whose clinical privileges are automatically suspended and/or who have resigned their medical staff membership for any of the reasons specified in Article VII, Section 4, are not entitled to any hearing or appellate review rights.

F. Hospital Policy Decision: The hearing and appeal rights of these bylaws are not available if the hospital makes a policy decision (e.g. physical plant changes, closing a department) that adversely affects the staff membership or clinical privileges of any member or applicant.

G. Failure to Meet Minimum Activity Requirements: Practitioners shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted, or terminated, or if their medical staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the medical staff bylaws. In such cases, the only review shall be provided by the medical executive committee, through a subcommittee consisting of at least three medical executive committee members who are appointed by the chief of staff. The medical executive committee shall give the practitioner notice of the reasons for the intended denial or change in membership, privileges, and/or category. If the practitioner disputes the reasons which are the basis for the intended denial or change in membership, privileges and/or category, the practitioner must notify the medical executive committee in writing of the dispute and the information, documents or other evidence upon which the practitioner bases the dispute, within thirty (30) days after the practitioner's receipt of the foregoing notice from the medical executive committee. If the practitioner requests an interview, the subcommittee shall schedule an interview with the subcommittee to occur no less than thirty (30) days and no more than one hundred (100) days after the practitioner requested the interview. At this interview, the practitioner may present evidence in support of why the action should not be taken. The subcommittee shall render a written decision within forty-five (45) days after the interview. A copy of the decision shall be sent to the practitioner, the medical executive committee and the governing board. The sub-committees decision shall be final unless it is reversed or modified by the medical executive committee within forty-five (45) days after the decision was rendered or by the governing board within ninety (90) days after the decision was rendered.

SECTION 12. Review of Non-MDCR Adverse Recommendation or Action

A. Review of Recommendations or Actions Not Subject to a Hearing.
If a recommendation or action as described in Section 2A has been taken pursuant to Section 2B, except that the recommendation or action is not based upon MDCR, the practitioner shall be notified by the Chief of Staff or designee. The practitioner who is subject to the action or recommendation may challenge it by filing a written request for review. Such request for review shall be delivered to the Chief of Staff and the Chief Executive Officer, either in person with receipted delivery, by receipted delivery service, or by certified or registered U.S. mail return receipt requested.

B. Interview
Upon receipt of the request for review, the Chief of Staff shall initiate a review. The Chief of Staff shall designate at least three members of the active Medical Staff to serve as a review committee and interview the affected practitioner. The Chief of Staff shall designate a chair of the committee. At least thirty (30) days prior to the interview, the Chief of Staff shall notify the affected practitioner and the Medical Staff

members who have been appointed to interview the practitioner, of the date, time, and place of the interview. The notice shall describe the acts, omission, or other basis upon which the recommendation or action is based. At least ten (10) days prior to the interview, the Medical Staff shall provide the practitioner copies of evidence which are the basis for the action or recommendation and the practitioner shall provide the Medical Staff copies of any evidence or other documentation which is the basis for the practitioner's objection to the decision or action. The designated committee, affected practitioner, Chief of Staff or designee, the Chief Executive Officer or designee, and the Medical Staff Office Director or assistant may be present during the interview. Attorneys may not be present at the interview. The procedures to be followed during the interview shall be as determined by the Chair of the Committee. The interview shall not constitute a "hearing" as described in these bylaws and the procedural rules applicable to Medical Staff hearings shall not apply. Information and documents not provided to the Medical Staff as part of the credentialing or peer review process, and information or documents not provided to the Medical Staff at least ten (10) days prior to the interview, shall not be accepted or considered during the interview. A report of the findings and the recommendations of the committee shall be made to the medical executive committee.

C. Medical Executive Committee Review
The medical executive committee shall review the recommendation of the committee and determine whether to revise its recommendation or action. The Chief of Staff then shall notify the affected practitioner and the governing board in writing of the medical executive committee's recommendation or action.

D. Governing Board Review
If the affected practitioner objects to the decision of the medical executive committee, the affected practitioner shall have thirty (30) days to submit a written notice to the governing board of his/her objections and request an interview before the governing board. The request shall specify all of the information and include copies of all documents which the practitioner believes support his/her position. The governing board shall have the option to elect to grant or deny the practitioner's request. If it elects to grant such request, the governing board shall conduct an interview, following such procedures as determined by the chair of the Governing Board. The interview shall not constitute an "appeal" as described in these bylaws and the procedural rules applicable to Medical Staff appellate reviews shall not apply.

ARTICLE IX. CATEGORIES OF THE MEDICAL STAFF AND CLINICAL PRIVILEGES

MS.2.3.4

SECTION 1. THE ACTIVE MEDICAL STAFF

Qualifications: Appointees to this category:

A. Must be involved in a minimum of twenty-four (24) patient contacts at the hospital annually unless otherwise specified in departmental rules and regulations after formal approval by the medical executive committee and governing board. Patient contacts are defined in Definitions

B. Must Actively participate in recognized functions of medical staff appointment, including quality improvement and other monitoring activities, in monitoring initial appointees during their provisional period, and in discharging other staff functions as may be required from time to time.

Prerogatives: Appointees to this Category:

A. May exercise the privileges granted without limitation, except as otherwise provided in the medical staff rules and regulations, or by specific privilege restriction.

B. May vote on all matters presented at department, committee, and special meetings of the medical staff.

C. May hold office and sit on or be chairperson of any committee or of their clinical department, unless otherwise specified elsewhere in these Bylaws or Rules and Regulations.

D. May contribute to the organizational and administrative affairs of the medical staff.

SECTION 2. COURTESY STAFF

Qualifications: Appointees to this category:

A. Must be able to document current competence by submission of documentation of records of patients (excluding patient name) treated at the practitioners office or another facility, in order to document current competence in privileges requested, with activity less than that required for active staff status in accordance with departmental rules and regulations requirements, and,

B. Must participate in performance improvement and other monitoring activities, in monitoring initial appointees during their provisional period, and in discharging other staff functions as may be required from time to time.

Prerogatives: Appointees to this Category:

A. May exercise the privileges granted without limitation, except as otherwise provided in the medical staff rules and regulations, or by specific privilege restriction.

B. May attend meetings of the staff and department to which s/he is appointed, committee meetings, and any hospital education programs.

C. May not vote on matters presented at department, committee, or special meetings of the medical staff.

SECTION 3. NON-ADMITTING MEDICAL STAFF

Qualifications: Appointees to this category:

A. May be professionals who dictate histories and physicals. Physicians in this category shall not have admitting privileges or in-patient care privileges, or

B. May provide an important resource for the medical staff performance improvement activities. Such individuals shall be qualified to perform functions for which they are granted privileges (i.e. special monitoring and evaluation, education/preceptorship for new procedures, etc.)

C. May participate as a Consultant on Peer Review Matters: In those cases where a peer review committee or department deems it necessary to obtain a review of a practitioner's practice by an outside consultant who is not a member of the medical staff, the outside consultant may be granted non-admitting privileges for the limited purpose of conducting the review, reporting to the peer review committee/department, and for testifying at a hearing or appeal with regard to that review.

D. May participant in a Medical Review Committee: In the rare situation where there are no qualified members of the medical staff able to act as a member of a medical review committee, non-admitting privileges may be granted to a qualified individual for the limited purpose of participating as a member of a medical review committee.

Prerogatives: Appointees to this category:

A. May utilize the hospital for the purpose of ordering of diagnostic and therapeutic testing only or those who hold privileges only for the purposes of quality improvement monitoring shall not be required to pay medical staff dues.

B. May attend meetings of the staff and department to which s/he is appointed, committee meetings, and any staff education programs.

C. May not vote

D. May not hold office

SECTION 4. PROVISIONAL STAFF

Qualifications:

A. Appointees to this category must complete the proctoring requirements of their assigned department. Monitoring shall require observation of care provided during the initial period of membership in order to recommend permanent staff membership. Appointees shall be provisional for no more than 12 months. (7/06) Failure to complete proctoring within this time frame shall be grounds for voluntary resignation of medical staff membership and clinical privileges without hearing rights.

Physicians who have been voluntarily resigned and have submitted a new application to the medical staff shall be appointed to the Provisional Staff unless otherwise designated by the Chief of Service.

Prerogatives: Appointees to this Category:

A. May Exercise privileges granted with appropriate oversight.
B. May attend meetings for the clinical department in which they are a member, committee meetings, and medical staff educational programs
C. May not vote
D. May not hold office

SECTION 5. Exceptions to Prerogatives

Regardless of the category of membership in the medical staff, oral surgeons, podiatrists, and clinical psychologists, only shall have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be resolved by the chair of the clinical department meeting, subject to a final decision by the medical executive committee.

SECTION 6. TEMPORARY PRIVILEGES

Qualifications: Prior to temporary privileges being granted, a practitioner must demonstrate that s/he has appropriate professional qualifications, including verification of an unrestricted, current and valid California license, a current and unrestricted DEA registration, if applicable, training and experience which verifies current competence, hospital affiliation and privileges, professional liability insurance coverage in the amount required by the governing board. The National Practitioner Data Bank must be queried prior to the granting of temporary privileges. By applying for temporary privileges all practitioners agree to be bound by the medical staff bylaws, rules and regulations, departmental rules and regulations and all applicable hospital policies.

Authority to Grant Temporary Privileges/Conditions:

The Chief Executive Officer or designee, with the concurrence of the chair of the applicable department or designee, and in the absence of the chair and designee, with the concurrence of the chief of staff, may grant temporary privileges under the circumstances noted below. In all cases, temporary privileges shall be granted for a specific period of time, not to exceed 30 days. After that period of time the practitioner may request an additional temporary privilege for another specific period of time, as deemed appropriate by the department, but not to exceed 30 days. Temporary privileges shall terminate automatically at the end of the specific period for which they were granted, without the hearing and appeal rights set forth in these bylaws. Special requirements of supervision and consultation may be imposed upon the granting of temporary privileges. Temporary privileges may not be granted for more than 120 days. No practitioner has the right to temporary privileges.

Temporary privileges may be granted for:

Care of a specific patient: Temporary privileges may be granted to a practitioner who is not an applicant for staff membership but whose services are required for the care of a specific patient and the required expertise is not available within the medical staff membership.

Denial, Termination, or Restriction of Temporary Privileges:

Temporary privileges, unless acted upon pursuant to other provisions of these bylaws, shall terminate automatically at the end of the specific period for which they were granted, without the hearing and appeal rights under these bylaws. The chief executive officer, chief of staff, or department chair, or their designees may terminate or restrict temporary privileges at any time with or without cause. No practitioner is entitled to the hearing and appeal rights set forth in these bylaws for the denial, non-renewal, restriction or termination of temporary privileges, unless such action must be reported pursuant to California Business and Professions Code, Section 805. In the event a practitioner's temporary privileges are terminated or restricted, the practitioner's patients then in the hospital shall be assigned to another practitioner by the department chair responsible for supervision or by the chief of staff. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

SECTION 7. EXPEDITED PRIVILEGES

Physicians awaiting approval by the Medical Executive Committee and Governing Board under the Expedited Credentialing portion of the Medical Staff Rules and Regulations shall be eligible for expedited privileges. These privileges may only be granted after approval by the Credentials Committee or Credentials Chair and the Chief of Clinical Department or designee.

SECTION 8. EMERGENCY PRIVILEGES

In the case of an emergency, any practitioner, to the degree permitted by licensure and regardless of department or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or s/he does not desire to request privileges, the patient shall be assigned to an appropriate member of the medical staff. For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger or in which any delay in administering treatment would add to that danger.

Emergency privileges may also be granted a practitioner in the event of a natural disaster, e.g. earthquake, or anytime the disaster plan has been activated. In this case a physician who is not a member of the medical staff may be granted special privileges to care for patients at this facility. In this case all possible information shall be collected, prior to the physician coming to the facility or within 72 hours, if feasible, including primary verification of licensure and other verifications possible. In this case, the Chief Executive Officer or his/her designee may grant emergency privileges on the recommendation of the chief of the applicable clinical department or his/her designee, if available or the chief of the medical staff. Once the disaster has passed, the full temporary privilege form shall be completed with back-up documentation to be the same as that required for any other temporary privilege request.

Emergency/Disaster privileges may be granted upon presentation of any of the following:

1. A current picture hospital ID card,
2. A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency,
3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
4. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
5. Personal knowledge by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity. (4/04)
6. Primary source verification of the license

Care provided by a physician granted Disaster Privileges shall be overseen by an Active member of the member of the medical staff with clinical record review conducted as soon as possible after the disaster is under control. (8/06)

SECTION 9. LOCUM TENENS PRIVILEGES

Locum Tenens privileges may be granted to a qualified practitioner serving as locum tenens for a member of the medical staff. Such privileges shall be limited based on the locum tenens practitioner's individual training, experience, and qualifications. The locum tenens practitioner will not be granted privileges in excess of those granted to the practitioner being temporarily replaced and the practitioner must hold at least the same level of training.

SECTION 10. EMERITUS STAFF STATUS

Emeritus status is restricted to those individuals the medical staff wishes to honor. Such staff appointees are not eligible to admit patients to the hospital, to exercise clinical privileges in the hospital, to vote, to hold office or to hold a position on a medical staff committee which is reserved for a member of the medical staff. They may, however, attend medical staff departmental and committee meetings as well as educational programs. Emeritus status may be granted to medical staff members who have retired from the active medical staff or who are of outstanding reputation. They shall not be required to pay dues. Approval of emeritus status is subject to a 2/3 majority vote of the medical executive committee.

SECTION 11. LEAVE OF ABSENCE

Members of the Medical Staff may apply for a leave of absence not to exceed one year. Request for leave must be in writing and include the reason for the leave of absence. By requesting a leave of absence the member understands and agrees that he/she will be treated as an initial applicant for the purpose of evaluating his/her qualifications for appointment and shall bear the burden of proof to demonstrate to the satisfaction of the Medical Executive Committee and Governing Board that he/she is qualified for initial appointment. Members of the staff shall be required to request a leave of absence for any anticipated absence over ninety (90) days. During the leave, the member shall not exercise clinical privileges and membership rights and responsibilities shall be inactive. Physicians on a leave shall not be required to pay dues during the period in which they are on leave. Dues shall be assessed upon return from the leave of absence. Members of the medical staff who are on a Leave of Absence are excluded from meeting attendance requirements during an approved leave.

Termination of Leave:
At least thirty (30) days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request appointment to the medical staff by submitting written notice to the Credentials Committee along with a request for an appointment packet. If requested, the individual shall complete an application for return from termination of leave. No application fee shall be assessed. Medical staff members requesting reappointment following a leave for medical reasons must provide documentation of medical clearance. The Credentials Committee or Medical Executive Committee may require that the applicant submit to an independent medical examination as part of the application process. Appointment may be subject to an observation requirement. Such routine observation shall not be considered disciplinary action and shall not entitle the practitioner to a hearing and appeal rights under these bylaws.

SECTION 12. MODIFICATION
At anytime within the two (2) year appointment cycle, and upon recommendation of the credentials committee, or pursuant to a members request, the medical executive committee may recommend a change in medical staff category.

ARTICLE X. OFFICERS

SECTION 1. OFFICERS OF THE MEDICAL STAFF
The Officers of the Medical Staff shall be:

A. Chief of Staff
B. Vice Chief of Staff
C. Secretary/Treasurer
D. Immediate Past Chief of Staff (no election)

SECTION 2. QUALIFICATIONS OF OFFICERS
Officers must be members of the active medical staff at the time of nomination and election and must remain members in good standing during their terms of office. Officers may not simultaneously be an officer of the medical staff or chief of service at another hospital.. Failure to maintain such status shall immediately create a vacancy in the office involved.

SECTION 3. ELECTION OF OFFICERS

A. Officers whose terms shall expire during the current medical staff year shall be elected through a mail balloting as delineated in the medical staff rules and regulations.

B. The composition of the nominating committee is delineated in the medical staff rules and regulations. The committee shall offer one or more nominees for each office and each at-large position on the executive committee that will expire at the end of the current medical staff year. Notice of its nominees shall be given to the medical staff at least thirty days prior to the voting.

C. Additional nominations may also be made in writing, signed by at least thirty-five (35) members of the active staff and delivered to the chief of staff. The medical staff shall be notified of such additional nominations by virtue of their inclusion on the ballot.

D. A candidate must receive a majority vote of those ballots returned. Where three or more candidates are nominated and no candidate received a majority vote the top two candidates shall

be in a run-off election. The candidate receiving a majority of the ballots returned shall be deemed to have been elected. The voting shall take place by secret written ballot.

SECTION 4. TERM OF OFFICE

All officers and at-large members of the executive committee shall serve two year terms from the date they take office or until successors are selected. Officers shall take office on the first day of the staff year.

SECTION 5. VACANCIES IN OFFICE

A. Vacancies in office during the medical staff year, except the office of chief of staff, shall be filled by the executive committee of the staff. If there is a vacancy in the office of the chief of staff, the vice chief of staff shall serve out the remaining term and it shall not be necessary to fill this resulting vacancy.

B. A medical staff officer may be removed for failure to perform his/her duties in accordance with these bylaws. Removal of medical staff officers during their term of office, for failure to perform his/her duties, may be initiated by a written letter, signed by at least twenty-five (25) active staff members and ratified by a two-thirds majority vote of the votes cast by the active medical staff members, but no such removal shall be effective unless and until it has been ratified by the executive committee and governing board.

C. A medical staff officer shall be removed immediately, without vote upon any of the following:
   1. Suspension or Revocation of professional license by the Medical Board of California
   2. Suspension from the Medical Staff (excluding medical record deficiencies less than 90 consecutive days in a reappointment cycle). Medical Record suspension greater than 90 consecutive days in a reappointment cycle shall result in immediate removal.

SECTION 6. DUTIES OF OFFICERS

A. Chief of Staff: The chief of staff shall serve as the chief executive officer of the medical staff. Duties of the chief of staff shall include those duties as defined in the medical staff rules and regulations. The chief of staff shall serve as an ex-officio, non-voting member on any and all medical staff committees and departmental meetings. He/she shall maintain voting rights in the department in which he/she is privileged and in order to break a tie at the medical executive committee meetings.

B. Vice-Chief of Staff: In the absence of the chief of staff, s/he shall assume all duties and have the authority of the chief of staff. He/she shall be a member of the executive committee. He/she shall automatically succeed the chief of staff when the latter fails to serve for any reason. Other Duties shall be as defined in the medical staff rules and regulations.

C. Immediate Past Chief of Staff: The duties of the immediate past chief of staff are principally advisory in nature. He/she shall serve as chair of the nominating committee and bylaws committee as well as serving on the executive committee.

D. Secretary/Treasurer: He/she shall be a member of the executive committee. The secretary/treasurer shall maintain an accurate accounting of the funds and act as the secretary in matters pertaining to the administration of the medical staff funds. Other duties shall be as defined in the medial staff rules and regulations.

ARTICLE XI. DEPARTMENTS

SECTION 1. ORGANIZATION OF DEPARTMENT

The medical staff shall be organized into departments with divisions. Each department shall have a chairperson with overall responsibility for supervision and satisfactory discharge of assigned functions.

A. DEPARTMENTS

Medical Staff Departments are defined as:

1. Department of Family Practice/Medicine (including Emergency Medicine, Radiology, and all medical sub-specialties)
2. Department of OB/GYN (including all sub-specialties of OB and Gynecology)

3. Department of Pediatrics (including Neonatology and Pediatric Intensive Care, and all pediatric sub-specialties)
4. Department of Surgery (including Anesthesiology, Pathology, and all surgical sub-specialties)

B.. DIVISIONS

Any group of physicians may organize themselves into a division within a department. Any division, if organized, will not be required to hold any number of regularly scheduled meetings, nor will attendance be required unless the division chairperson calls a special meeting to discuss a particular issue. A division may develop rules which specify the method of selecting its chair and its purposes and responsibilities. Special meetings must be preceded by at least two weeks prior notification for all of those expected to attend.

Divisions may perform any of the following activities on behalf of the overseeing clinical department(s), however, responsibility and accountability for performance of department functions shall remain at the department level.

1. Continuing education;
2. Grand rounds;
3. Discussion of policy;
4. Discussion of equipment needs;
5. Development of recommendations for department director to discuss at the departmental meetings for possible recommendation to medical executive committee;
6. Participation in the development of criteria for clinical privileges.
7. Discuss a specific issue at the special request of a department chairperson

Minutes of each meeting shall be taken, retained and filed at the hospital.

Divisions may request a seat on the medical executive committee with or without voting rights. This may be accomplished by submitting documentation, which supports the requirements set forth in the criteria for membership as delineated in the medical staff rules and regulations.

The divisions of anesthesiology, emergency medicine, pathology, and radiology shall each hold a representative seat on the medical executive committee with voting rights.

SECTION 2. QUALIFICATIONS, SELECTION, TENURE , AND FUNCTIONS OF DEPARTMENT CHAIRS

A. QUALIFICATIONS: Each chair shall be a member of the active medical staff, and be certified by an appropriate specialty board or have affirmatively established that he/she has training and experience equivalent to board certification through the privilege delineation processes, and who has demonstrated his/her ability for the position, as determined by the active medical staff vote of the department and shall have maintained clinical privileges in that department. Additionally, s/he shall meet the qualifications and perform the functions specified for the position.

B. SELECTION AND TENURE SHALL BE IN ACCORDANCE WITH RULES AND REGULATIONS

C. VICE-CHAIR: The vice-chair of the department shall be selected by the department chair after he/she is elected and shall represent the department at the medical executive committee during the absence of the chair. The vice-chair may not be in the same clinical office or medical group as the department chair.

D. REMOVAL FROM OFFICE: Department chairs or vice-chairs may be removed from office by initiation of a two-third majority of the votes cast by the active medical staff members of the department. No such removal shall be effective unless and until it has been ratified by the executive committee and by the governing board. Removal is final and none of the provisions of Hearing Rights shall apply.

E. VACANCY IN OFFICE: As defined in the Rules and Regulations.

SECTION 3. FUNCTIONS OF DEPARTMENT CHAIRPERSONS

Each clinical department chairperson shall have the following duties and authority and such other duties as may from time-to-time reasonably be requested by the chief of staff or medical executive committee

1. Be accountable for all professional and administrative activities within his/her department.

2. Be a member of the medical executive committee, giving guidance on the overall medical policies of the hospital and making specific recommendations and suggestions regarding his/her own department in order to assure quality patient care including but not limited to needed off-site patient care services not provided by the hospital and the assessment of these services. (revised 9/02).

3. Represent or appoint a representative of the department as a member of the credentials and interdisciplinary practice committees as well as any other committees as requested.

4. Be responsible for assisting in the development, implementation, and enforcement of the hospital bylaws and of the medical staff bylaws, rules and regulations and policies and procedures within his/her department in order to integrate with the primary functions of the organization, guiding and supporting the overall provision of services.

5. Be responsible for implementation within his/her clinical department of actions taken by the medical executive committee and assisting in the coordination and integration of interdepartmental and intradepartmental services, eg. Peer and Chart Review responsibilities.

6. Transmit to the medical executive committee his/her department's recommendations concerning the staff classification, the appointment, reappointment and delineation of clinical privileges for all practitioners to his/her department. This shall include the recommending of criteria for clinical privileges relevant to the care provided in the department. (revised 9/02)

7. Be responsible for teaching, education, continuous quality improvement, and research programs including surveillance of the professional performance of all individuals in the department who have delineated clinical privileges. (revised 9/02)

8. Participate in every phase of administration of his/her department through cooperation with the nursing services and hospital administration in matters affecting patient care, including personnel, supplies, space planning, special regulations, standing orders, and techniques; and assure coordination and integration of interdepartmental and intradepartmental services. (9/02)

9. Assist in the preparation of such annual reports, including budgetary planning, pertaining to his/her department as may be required by the medical executive committee, the chief executive officer, or the governing board.

10. Be responsible to develop and implement monitoring and evaluation activities to evaluate the appropriateness and quality of clinical services provided for the purpose of identification and resolution of problems and identification of opportunities to improve care.

Be responsible for recommending criteria for clinical privileges to his/her department.

Be responsible for assuring the determination of qualifications and competence of department or service personnel who are not licensed independent practitioners who provide patient care services.(9/02)

Recommend sufficient number of qualified and competent persons to provide care, treatment, and services as required, eg. Staffing for Emergency Department or other Clinical areas.

SECTION 4. FUNCTIONS OF DEPARTMENTS

Each department shall recommend criteria, consistent with the bylaws and regulations of the medical staff and of the board, for the granting of clinical privileges.

SECTION 5. ASSIGNMENT TO DEPARTMENTS

The medical executive committee will, after consideration of the recommendations of the chair of the appropriate clinical department(s), recommend department assignments for all medical staff members in accordance with their qualifications. Each member of the medical staff shall be assigned membership to one department but may be granted clinical privileges in other departments.

ARTICLE XII. COMMITTEES

SECTION 1. MEDICAL EXECUTIVE COMMITTEE

A. Composition: The medical executive committee shall include the chief of staff, vice-chief of staff, immediate past chief of staff, secretary/treasurer, credentials committee chair, director of medical education, two members-at-large (elected in the same manner as the officers of the medical staff), chair of each clinical department and a representative of each of the following specialty, division, or groups of specialists who is elected to two-year terms by the active members of the specialty. The representatives of the divisions, specialties, or groups of specialists to be included, with voting ability:

1. Anesthesiology
2. Emergency Medicine
3. Pathology
4. Radiology
5. Cardiac Services
6. Family Practice/ Medicine (whichever specialty is not currently represented as the departmental chair)
7. Medical Education -The chair of the medical education committee shall be appointed by the chief of staff and ratified by the Medical Executive Committee. The chair shall select his/her committee members.

Additional representatives of divisions, specialties, or groups of specialists may apply for a seat on the medical executive committee, with or without voting rights.

The chief executive officer will be an ex-officio member without vote. The chief of staff will be chairperson of the medical executive committee.

The administrative representatives (including the CEO, chief nursing officer(s), and operating officer(s) present at a meeting may be excused any time during a meeting that the chief of staff deems it appropriate in order to allow for confidential medical staff discussion of issues. Should these individuals be excused from the meeting, the chief of staff shall, immediately following the meeting, contact the CEO and notify him/her of the issues raised at the meeting and any resolutions passed.

B. Duties: The duties of the medical executive committee shall be:

1. To represent and act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;
2. To coordinate the activities and general policies of the various departments;
3. To receive and act upon departmental and committee reports;
4. To implement policies of the medical staff not otherwise the responsibility of the departments;
5. To provide liaison between the medical staff and the chief executive officer;
6. To recommend action to the chief executive officer on medico-administrative matters;
7. To make recommendations on hospital management matters and policies, i.e. long-range planning, to the governing board;
8. To ensure that the medical staff is kept abreast of the accreditation program and informed of the accreditation status of the hospital;
9. To fulfill the medical staff organization's accountability to the governing board for the medical care of patients in the hospital;

10. To review the report of the credentials committee on all applicants and to make recommendations for staff membership, assignments to departments, and delineation of clinical privileges;
11. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance for all members with clinical privileges including, but not limited to overseeing and participating in, the medical staff's performance improvement activities, peer review, corrective action, and fair hearing procedures.
12. To act on behalf of the medical staff in the intervals between medical staff meetings.
13. To review and approve the designation of the hospital's authorized representative for National Practitioner Data Bank purposes.
14. To Conduct such other functions as are necessary for the effective operation of the medical staff; and

C. Meetings: The medical executive committee shall meet at least quarterly, but as often as necessary to fulfill its responsibility. Permanent record of the proceedings and actions shall be maintained. Special meetings of the medical executive committee may be called at any time by the chief of staff.

SECTION 2. STAFF FUNCTIONS

Provision shall be made in these bylaws or by resolution of the medical executive committee, approved by the governing board, either through assignment to the departments, to medical staff committees, to medical staff officers or officials, or to interdisciplinary hospital committees, for the effective performance of the medical staff functions specified in this section and described in the rules and regulations of the medical staff and of such other staff functions as the medical executive committee or the governing board shall reasonably require. These are to:

1. Monitor and evaluate care provided in and develop clinical policy, the foregoing to include but not be limited to, special care areas, such as intensive or coronary care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care, and other ambulatory care services;
2. Monitor quality, appropriateness and improvement activities, including, but not limited to: invasive procedures, blood usage, pharmacy and therapeutics including drug usage review and surveillance over drug utilization policies and practices, tissue review, medical records including clinical pertinence, patient safety, nosocomial infections and the hospital's Infection Control Program, and other reviews as necessary;
3. Participate in utilization review activities;
4. Conduct or coordinate credentials investigations for staff membership and granting of clinical privileges and specified services;
5. Provide continuing medical education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments and other perceived needs, and supervise the hospital's professional library services;
6. Participate in the planning of response to:
   a. fire and other disasters,
   b. hospital growth and development, and
   c. the provision of services required to meet the needs of the community;
7. Direct all medical staff organizational activities, including:
   a. medical staff bylaws and rules and regulations, review and revision of the foregoing,
   b. staff officers and committee nominations,
   c. liaison with the governing board and administration, and
   d. review and maintenance of hospital accreditation;
8. Monitor the care provided by members of the medical staff, the care provided by nursing and other patient care activities that potentially affect patient care.
9. Assisting medical staff members who may be impaired by chemical dependency, physical illness, and/or mental illness to obtain necessary rehabilitative services; and
10. Maintain confidentiality of peer review information, which grants immunity from liability and includes a release of liability.

ARTICLE XIII. MEDICAL STAFF MEETINGS

SECTION 1. SPECIAL MEETINGS - GENERAL STAFF

A. The chief of staff may call a special meeting of the medical staff at any time. The chief shall call a special meeting within 20 days after receipt of a written request for such a meeting signed by not less than one-fourth of the active medical staff, or upon a resolution by the medical executive committee. Such a request or resolution shall state the purpose of the meeting. The chief of staff shall designate the time and place of any special meeting.

B. Written or printed notice stating the time, place and purpose(s) of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least seven (7) days before the date of such meeting. The attendance of a member of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

SECTION 2. REGULAR MEETINGS

Committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution. Departments shall meet at least quarterly or more frequently at the discretion of the chair.

SECTION 3. SPECIAL MEETINGS - DEPARTMENT OR COMMITTEE

A special meeting of any committee or department may be called by or at the request of the chair thereof, or by the chief of staff.

SECTION 4. QUORUM

The quorum requirement for the following meetings shall be:

A. Medical Staff Meetings: Those members of the active staff present and voting, but not less than two.

B. Medical Executive Committee: Those members of the committee so designated with voting rights present and voting, but not less than one third of the voting members present.

C. Department/Division/Committee Meetings: Those members of the active staff present and voting but not less than two.

SECTION 5. ATTENDANCE REQUIREMENTS

A. Members of the medical staff are encouraged to attend meetings of their clinical department. Departmental and Committee general meeting requirements are delineated in the medical staff rules and regulations.

B. Medical executive committee and credentials committee meetings: Members of the medical executive committee and credentials committee are required to attend at least seventy-five percent (75%) of the meetings held.

C. Special Attendance Requirements or Conferences: Whenever a suspected deviation from standard clinical or professional practice or from acceptable conduct or behavior is identified, the chair of the applicable clinical department may require the practitioner to confer with him/her or with a standing or ad hoc committee considering the matter. The practitioner will be given special notice of the conference at least five (5) days prior to the conference, including the date, time and place, a statement of the issue involved, and a statement that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such conference, unless excused by the medical executive committee, upon showing good cause, will result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the medical executive committee may direct. A suspension under this section will remain in effect until the matter is resolved by subsequent action of the medical executive committee and governing board. Such resolution shall be made in a timely manner.

SECTION 6. CONFLICT OF INTEREST

At the discretion of the Chair of the meeting or a majority of those members in attendance, an individual who has a direct personal or financial interest in the outcome of a decision or whose care, conduct or qualifications is a subject under discussion a the meeting, may be required to leave the meeting while the members complete their discussion and vote on the matter. If the Chair is the subject of the matter, the Vice-Chair shall act in the Chair's behalf in determining whether the Chair should be excused and then chairing the meeting during the Chair's absence.

SECTION.7. PARTICIPATION BY THE CHIEF EXECUTIVE OFFICER
The chief executive officer or designee may attend any committee, department, or division meetings of the medical staff.

SECTION 8. NOTICE OF MEETINGS
Written notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee, department, or division not less than three days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

SECTION 9. ACTION OF COMMITTEE/DEPARTMENT/DIVISION
The action of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee, department, or division.

SECTION 10. RIGHTS OF EX-OFFICIO MEMBERS
Except as otherwise provided in these bylaws, when the Chief Executive Officer attends a meeting, and when the Chief of Staff attends any department, division or committee meeting other than the medical executive committee and the department in which s/he is a member, those individuals shall have all rights and privileges of regular members thereof, except that they shall not vote or be counted in determining the existence of a quorum.

SECTION 11. MINUTES
Minutes of each regular and special meeting of a committee, or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer and submitted to the medical executive committee. Minutes of each committee, division, and department meeting shall be maintained in a permanent file.

ARTICLE XIV. ALLIED HEALTH PROFESSIONALS

SECTION 1. CATEGORIES OF ALLIED HEALTH PROFESSIONALS
The governing board shall determine, based upon comments by the medical executive committee and other information as it has before it, those categories of allied health professionals that shall be eligible to exercise privileges in the hospital. If it is determined that a licensure category does not represent a needed service, the clinical privileges shall not be permitted for professionals in that licensure category.

SECTION 2. LIMITATIONS AND RESTRICTIONS TO APPOINTMENT
AHP's shall not be eligible for appointment to or membership on the Medical Staff. Patients may only be admitted to the Hospital by a practitioner who has admitting privileges. The general qualifications to be required of members of each category of AHP shall be recommended by the Committee on Interdisciplinary Practice in conjunction with the clinical department concerned. The chair of the committee on interdisciplinary practice shall submit a list of such qualifications to the executive committee for approval.

SECTION 3. APPLICATION FEES AND YEARLY DUES
Allied Health Professionals shall be assessed an application fee and annual dues, The exception to this would be those AHP's who only provide services as employees of the Hospital who shall not be required to pay an application fee or yearly dues. The amount of the application fee and yearly dues shall be determined and voted upon by the medical executive committee.

SECTION 4. APPOINTMENT
Applications for privileges and renewal thereof shall be processed and information verified through the same channels as those for medical staff membership. All completed credentials shall be reviewed by the committee on interdisciplinary practice. Privileges shall be considered and recommended by the committee of the medical staff.

A. Allied Health Practitioners are health care providers who:
   1. hold a current, valid and unrestricted license, certificate, or other legal credential as required by this state which authorizes the AHP to provide patient care services;

2. are in a category of AHPs designated by the governing board to carry out privileges under defined degree of supervision and monitoring;
3. meet the qualifications in these bylaws, rules and regulations, and applicable hospital policies;
4. AHP's are not entitled to medical staff membership or prerogatives;
5. AHP's are not entitled to hearing or appeal rights in Article VIII of the medical staff bylaws
6. Nothing in these bylaws is to be interpreted to construe AHPs as a separate or self-governing entity.
7. Must consent to a criminal background check

B. QUALIFICATIONS: To be eligible for, and to maintain clinical privileges and membership as an AHP, at a minimum, the AHP must meet each of the following requirements in addition to any requirements recommended by the medical staff executive committee and required by the governing board:

1. hold a current, unrestricted license, certificate, appropriate legal credential in a category of AHPs that the governing board has identified as eligible for privileges;
2. document his/her background, relevant training, education, experience, demonstrated current competency, judgment, character, and physical and mental health status (subject to reasonable accommodation if and to the extent required by law), with sufficient adequacy to demonstrate that patient care services will be provided by the AHP at the professional level of quality and efficiency established by the medical staff and governing board.
3. submit an application for clinical privileges on the form prescribed by the medical staff and governing board, providing all requested information and documentation;
4. provide a written confirmation of the existence and extent of required supervision by a physician member of the medical staff as required by the governing board;
5. document his/her strict adherence to the ethics of this Medical Staff and AHP's respective profession; his/her ability and agreement to work cooperatively with others in the hospital setting; and his/her willingness to commit to and regularly assist the hospital in fulfilling its obligations related to patient care within the areas of the AHP's professional competence and credentials; and
6. maintain professional liability insurance in amounts, of a type, and with a carrier as required by the medical executive committee and governing board.

SECTION 5. PROVISIONAL PERIOD

All allied health professionals shall undergo a Provisional period for a minimum of one year, not to exceed a two-year period from the time of appointment. during which time the following should occur: A minimum of six (6) proctoring reports are required for review by the appropriate clinical department to satisfactorily indicate completion of the proctoring program for Allied Health Professionals

Following are specific proctoring requirements for dependent and independent Allied Health Professionals:

DEPENDENT PRACTITIONERS (e.g., RNFA, Nurse Practitioner, RN, Scrub Tech, etc.)
Dependent practitioners would be required to undergo evaluation by way of proctoring. The sponsoring physician(s) shall be required to complete the proctorings on cases in which they participated. The evaluation would be submitted to the appropriate medical staff department for evaluation. At this time a provisional evaluation would be completed to include a minimum of six (6) satisfactory proctoring reports.

INDEPENDENT PRACTITIONERS (e.g., Optometrists, Acupuncturists, etc.)
The independent practitioner shall be required to submit a list of six (6) cases for evaluation and monitoring by the appropriate clinical department.

Proctoring of specific types of procedures or activities may be initiated at any time when it is deemed necessary by the sponsoring physician and/or the clinical department. Any clinical department may require more than (6) proctored cases for a specific applicant at its discretion.

Failure to submit the necessary documentation for monitoring and evaluation purposes at the end of the provisional period would be deemed a voluntary resignation from the allied health professional staff without hearing or grievance rights.

SECTION 6. PROCESSING FOR REAPPOINTMENT

All allied health professionals shall be required to submit a reappointment packet at least every two (2) years. This reappointment packet shall include at least the following:

1. Completed reapplication form, signed and dated.
2. Evidence of continuing education, as required by licensure.
3. History of Malpractice cases during the last two years.
4. Letter of Sponsorship for dependent allied health professionals.
5. Current California Licensure or Training Certification.
6. Malpractice Policy Certification/Claims History.
7. Hospital Reference Letter (if applicable)
8. Updated delineation of privileges.
9. Letter of verification of current competence from sponsor for dependent Allied Health Professionals.
10. Acknowledgment of current competence from the director of medical/surgical service under which the independent allied health professional is practicing.
11. Peer recommendation letter
12. Consent for Criminal Background Check

Once all of the aforementioned information has been obtained the reappointment packet shall be submitted to the interdisciplinary practice committee and appropriate clinical department for review. The applicant would then be presented to the medical executive committee for approval of reappointment.

The reappointment process shall be the same as that for a member of the medical staff.

SECTION 7. ASSIGNMENT

AHP's shall be individually assigned to an appropriate clinical department. The AHPs' shall carry out their professional activities under the supervision of the committee of interdisciplinary practice and the chair of the clinical department or the appropriate attending staff member assigned this responsibility, and subject to departmental rules and regulations.

SECTION 8. DUTIES AND PREROGATIVES

1. AHP's shall participate directly in patient management as consistent with the practice privileges granted to the AHP's and within the AHP's licensure or certification;
2. An AHPs' prerogatives may be extended to include service on medical staff, department, and hospital committees, attendance at the meetings of the department to which he/she is assigned, as permitted by the departments' rules and regulations, and attendance at hospital educational programs in his/her field of practice;
3. An AHP shall participate as appropriate in patient care audit and other quality review, evaluation and monitoring activities required of AHPs', supervising initial appointee's of his or her same occupation or profession or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.
4. At all times, an AHP shall meet those responsibilities required by the medical staff rules and regulations, and if not so specified, meet the responsibilities specified in the medical staff bylaws, as are generally applicable to the more limited practice of the AHP.
5. Although ultimate responsibility for patient care always shall rest with a member of the medical staff, an AHP shall retain appropriate responsibility within his/her area of professional competence for the care and supervision of the patient in the hospital for whom he/she provides service.
6. AHP's shall be permitted to write orders to the extent established by the departmental policies and procedures and within the scope of their licensure and applicable statutes, and as granted by their clinical privileges

7. The scope of an AHP's duties shall be specifically listed in the delineation of privileges for each category. Any new duties requested would require appropriate documentation of training and experience as well as coverage under the scope of licensure for that category.
8. Maintain the confidentiality of all peer review related matters and waive any right under state law to voluntarily disclose such matters.

SECTION 9. TERMINATION OF PRIVILEGES

Nothing herein shall create any vested rights in any AHP to receive or maintain any privilege in the hospital. The provisions of the medical staff bylaws specifically relating to Corrective Action and Hearing and Appellate Review Procedures shall not apply to an AHP applying for privileges or one to whom such privileges already have been granted. An AHP's clinical privileges shall terminate automatically at the sole discretion of the Chief Executive Officer, Chief of Staff or chair of the department upon occurrence of any of the following:

1. suspension, restriction, termination, voluntary relinquishment, expiration, or the imposition of terms of probation (whether voluntary or involuntary) on the medical staff membership or privileges of any supervising practitioner'
2. termination of the supervisory/sponsoring relationship between the AHP and the supervising practitioner;
3. suspension, revocation, expiration, voluntary or involuntary relinquishment or restriction, termination, or imposition of terms of probation by the applicable licensing or certifying agency of the AHP's license, certificate or other legal credential which authorizes the AHP to provide health care services;
4. failure of the AHP to perform properly assigned duties including but not limited to medical record completion;
5. conduct by the AHP which interferes with or is detrimental to the provision of quality patient care;
6. failure of the AHP to maintain professional liability insurance as required;
7. failure of the supervising physician to maintain professional liability insurance as required;
8. failure of any supervising practitioner to maintain active staff membership and clinical privileges in good standing;
9. termination of the supervising practitioner's professional services contract, if any, with the hospital;

SECTION 10. GRIEVANCE PROCESS

Within fifteen (15) days following any action that would constitute grounds for a hearing under the Appellate Review Procedures of the medical staff bylaws pertaining to Initiation of a Hearing, an AHP shall have the right to file written grievance with the executive committee. Upon receipt of such a grievance, the executive committee shall conduct a review that affords the AHP an opportunity of an interview concerning the grievance. The interview shall not constitute a "hearing" as established in the Appellate Review Procedures of the medical staff bylaws and need not be conducted according to the procedural rules applicable to those hearings. Before the interview, the AHP shall be informed of the general nature of the circumstances giving rise to the action and the AHP may present relevant information at the interview. A record of the interview shall be made and a decision on the action shall be made by the medical executive committee. The Chief of Staff shall notify the AHP of the medical executive committee's decision. If the AHP disagrees with the medical executive committee's decision, the AHP has the right to request that the governing board review the medical executive committee's decision. Such request must be submitted to the CEO within fifteen (15) days following the AHP's receipt of the medical executive committee's decision, and include all information and documentation which the AHP believes support the AHP's position. Upon receipt of such request, the governing board shall have the option to either grant an interview to afford the AHP an opportunity to present his/her objections following such procedures as the governing board may establish, to reject the request and affirm the decision of the medical executive committee, or to refer the matter back to the medical executive committee for further consideration.

ARTICLE XV. PRACTITIONER RIGHTS

In addition to the rights set forth in these bylaws,

SECTION 1.
Each physician on the medical staff has the right to an audience with the medical executive committee. In the event a practitioner is unable to resolve a difficulty working with his/her respective department chair that physician may, upon presentation of a written notice, meet with the medical executive committee to discuss the issue.

SECTION 2.
Any practitioner may challenge a rule or policy established by the executive committee. In the event a rule, regulation or policy is felt to be inappropriate, any physician may submit a petition, signed by at least one tenth of the members of the active staff. When such petition has been received by the medical executive committee, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issue.

SECTION 3.
Any section/subspecialty group may request a department meeting when a majority of the members/subspecialists believe that the department has not acted appropriately.

ARTICLE XVI. REVIEW, REVISION, ADOPTION, AND AMENDMENT OF THE BYLAWS

The medical staff bylaws, and rules and regulations of the medical staff do not conflict with the governing board bylaws

SECTION 1. MEDICAL STAFF RESPONSIBILITY
The medical staff shall have the responsibility to formulate, adopt and recommend to the governing board, medical staff bylaws and amendments thereto which shall be effective when approved by the governing board. Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the rules and regulations, policies, and protocols developed to implement various sections of these bylaws.

SECTION 2. METHODS OF ADOPTION AND AMENDMENT
These bylaws may be adopted or amended by a mail ballot in the manner described, by a positive vote of a majority of the active medical staff members who vote. The bylaws or an amendment to the bylaws may be proposed by either:

A. The medical executive committee; or
B. Any member of the active medical staff whose petition for amendment bears the signature of twenty-five (25) active medical staff members; or
C. The governing board.

Proposed bylaws or amendments proposed pursuant to B or C above first will be presented to the medical executive committee at any regular meeting after notification to the chief of staff at least three (3) days prior to the scheduled meeting. The medical executive committee may, at its option recommend approval or disapproval of the bylaws or the proposed amendment, but must submit the proposed bylaws or amendment for a vote of the active medical staff, by mail ballot, within ninety (90) days of its submission to the medical executive committee. Bylaws or amendments proposed by the medical executive committee must be submitted to the active medical staff by mail ballot, within ninety (90) days after the proposal by the executive committee.

The mail ballot will indicate which portions of the bylaws are affected or deleted, including a copy of the proposed bylaws or amendment(s) and contain provisions which permit the active medical staff member to approve or disapprove the proposal. All ballots are to be returned within fifteen (15) days, and shall be counted by the officers of the medical staff or their designee, who will certify the vote, and if approved by the governing board, become effective immediately thereafter. The Medical Staff shall be informed of any amendments to the bylaws.

The executive committee, may, at its option, present for discussion, but not voting, the proposed bylaws or amendment(s) at a special meeting of the active medical staff called for this purpose. Proposed bylaws or amendments to be voted upon must submitted for a mail vote by the active staff within ninety (90) days of its submission and adoption by the medical executive committee.

No bylaws or amendments thereto shall become effective unless and until approved by the governing board, such approval not to be unreasonably withheld. In the event the board does not take any action to review, process, reject, approve or otherwise respond to the proposed bylaws within ninety (90) days after the bylaws have been approved by the medical staff and received by the governing board, the bylaws shall be deemed approved by the board. If the approval is withheld, the board shall state, in writing, its reasons for the denial and forward its reasons to the chief of staff, the executive committee, and the bylaws committee.

SECTION 3. RULES AND REGULATIONS

The medical executive committee will recommend to the board medical staff rules and regulations which include departmental rules and regulations and proctoring requirements, and further defines the general policies contained in these bylaws. Upon adoption by the board, these rules and regulations will be incorporated by reference and become part of these medical staff bylaws, without the requirement of a medical staff vote. If there is a conflict between the bylaws and the foregoing rules and regulations, the bylaws shall prevail.

SECTION 4. JOINT CONFERENCE AMENDMENT

If the governing board has determined not to accept a recommendation submitted to it by the medical executive committee, the medical executive committee is entitled to a joint conference between the officers of the board and the officers of the medical staff. Such joint conference shall be for purposes of further communicating the board's rationale for its contemplated action, and to permit the officers of the medical staff to fully articulate the rationale for the medical executive committee's recommendation. Such a joint conference will be scheduled by the chief executive officer within two weeks after receipt of a request of same submitted by the chief of staff. Notwithstanding the foregoing, in matters regarding recommendations and/or actions specific to the membership and/or clinical privileges of a Medical Staff member or applicant, or specific to the privileges of an Allied Health Practitioner or applicant, the procedures set forth in Articles V, VI, VII, VIII, and XIV, shall be followed.

If the matter is not resolved by the Joint Committee and is a dispute relating to self-governance as set forth in California Business and Professions Code Section 2282.5, the dispute shall be referred to the Ad Hoc Dispute Resolution Committee.

ARTICLE XVII. MEDICAL STAFF SELF GOVERNANCE

All policies, procedures, protocols, criteria, standards or guidelines related to Medical Staff Self-Governance activities shall be set forth in the bylaws, rules and regulations or the Medical Staff or other documents which shall be deemed to be part of the bylaws, rules and regulations upon approval by the Medical Executive Committee and Governing Board. Such self-governance activities include, but are not limited to, standards and criteria for Medical Staff membership, standards and criteria for clinical privileges, procedures for enforcement of such standards and criteria, quality improvement, utilization management, and review and analysis of patient medical records.

ADOPTED BY THE MEDICAL STAFF, SUBJECT TO THE GOVERNING BOARD APPROVAL

BY:_____ **DATE:**_____ **Chief of Staff**

Approved by the Governing Board:

BY:_____ **DATE:**_____ **Governing Board Chair**

Revised 11/97
Revised 12/09/97
Revised 2/10/98
Revised 4/30/99
Revised 6/25/99
Revised 7/99

Revised 8/99
Reviewed/revised 5/02
Reviewed/revised 11/02, 12/02
Reviewed/revised 2/06/03
Revised 3/04
Revised 4/04
Revised 1/05
Revised 6/05
Revised 7/06
Revised 8/06

Appendix IV: Structured Review Forms

- Initial Document Review and Site Visit Review
- Minutes and Site Visit Review
- Document Review for MBC
- Comprehensive Peer Review Project, Validation Phase, Medical Director Review
- Peer Review Survey: Data Validation Template

Initial Document Review and Site Visit Review

Organization Name_____

Organization Type 1Hospital 2Health Plan 3Medical Group 4Professional Society

Organization Number_____

Provided documents Y N partial

Blank forms sent Y N

Description of process Y N
Bylaws Template used Y N

By reference to law
805 mentioned Y N 821.5 mentioned Y N
Process outlined Y N Process outlined Y N

809 mentioned Y N
Process outlined Y N

Additional Information Y N
Tiered process Y N
Flow Sheet Y N
Rating/Category System for events Y N
Rating/category system for actions Y N
Categories defined Y N P
Actions defined Y N P
Definitions 1 2 3 4 5 (most explicit)

Other Information
Community or Governing Bylaws Y N
Policy or Procedure Y N
Med Staff Rules & Regs Y N

805s sent Y N
805 description sent Y N
Outcomes Y N

Event Summary sent Y N

Additional Timeline Information Y N

Minutes Sent Y N some

5 years of minutes Y N partial

Comprehensive tracking system UK 1 2 3 4 5 (most comprehensive)

Communicated through Attorney Y N Partially

Referred to October Conference Call in cover letter Y N

Tables sent with initial document request:
Table 1
Documents from each Peer Review Body

Required Documents	Provided Yes/No	Not applicable to this organization
Charters		
Bylaws		
Policies		
Procedures		
Minutes/Agendas Sept 2002-Sept 2007		
Peer review reporting forms with definitions		
Table of peer reviewed cases Sept 2002-2007		

Table 2
Template for Peer Review Cases for years Sept 2002-Sept 2007

Date of Incident or Complaint	Provider	Potential Type of Review (805 or 821.5)*	Medical Record Number	Patient age, gender, ethnicity	Circumstances of the peer review	Reported to MBC Yes/No	If No, Specific Reason/s for not reporting to MBC	If Yes, Date reported to MBC

- 805 report-"Medical disciplinary cause or reason" means that aspect of a provider's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
- 821.5-investigation of a physically or mentally disabled provider

Minutes and Site Visit Review

Organization Name_____

Organization Type 1Hospital 2Health Plan 3Medical Group 4Professional Society

Organization Number_____

Event Summary sent Y N

Minutes Sent Y N

Are cases tracked over time consistently Y N

Are cases reported to appropriate groups by policy Y N

5 years of minutes Y N

If not 5 years, was there sufficient evidence of a tracking system in any documents? Y N

Comprehensive tracking system UK 1 2 3 4 5 (most comprehensive)

Evidence in the minutes_____

Evidence in an event summary_____

Other _____

Table 2
Template for Peer Review Cases for years Sept 2002-Sept 2007

Date of Incident or Complaint	Provider	Potential Type of Review (805 or 821.5)*	Circumstances of the peer review	Reported to MBC Yes/No	If No, Specific Reason/s for not reporting to MBC	If Yes, Date reported to MBC

- 805 report-"Medical disciplinary cause or reason" means that aspect of a provider's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
- 821.5-investigation of a physically or mentally disabled provider

Document Review for MBC

The review will include

1. assessment of timeliness of reports received;

    a. map length of time from date of peer review body determination to submission date of report to the Board;
        i. length of time from date of PR body determination to submission date of report to MBC
        ii. completeness of 805 or 821.5 reports
        iii. for incomplete forms, does MBC have to verify or obtain additional information

    b. is there a difference between accuracy and timeliness of 805 reporting vs. 821.5 reporting
    c. follow through several cases to get total picture of physician, hospital, and MBC roles; responsibilities and outcomes; effect on patient safety and public protection

2. review of process when cases are submitted

    a. review/flow-chart of activities

3. review of adherence to disclosure of actions taken by the Board

4. measure of frequency of Board sanction determinations

As necessary, review documents related to Section 805 and 821.5 processes (last 5 years).

1. Charters
2. Bylaws
3. Minutes
4. Policies and Procedures
5. Minutes

Comprehensive Peer Review Project
Validation Phase
Medical Director Review

Organization Name: Organization #

Organization Type: 1) Hospital 2)Health Plan 3)Medical Group 4) Professional Society

Organization Survey Response - Specific Policy & Procedure Review – (Did the organization follow their internal policies/procedures?)

805 Report Case Review – Reported to MBC
Provider ID# -a Date of Incident/Complaint:_____Date reported to MBC_____
Circumstances of Review:

Do you agree with the organization's decision to forward the case to MBC and why (were the findings of the peer review committee in the best interest of patient care)?

High Level Case Review – Not reported to MBC
Provider ID# -b Date of Incident/Complaint_____
Circumstances of Review:

Do you agree with the organization's decision not to forward to MBC and why? (were the findings of the peer review committee in the best interest of patient care)?

_____ _____
Medical Director Signature Date of Review

Peer Review Survey
Data Validation Template

Organization # _____

Organization Type

Options	Survey Result	Validation Result
Hospital		
Professional society		
Medical Group		
Health Plan		

The major/final Peer Review Body in this organization is called: (check all that apply)

Options	Survey Result	Validation Result
Care Review committee		
Credentialing committee		
Licensing/Credentialing committee		
Medical Department committee/s		
Medical Staff Executive committee		
Peer review committee		
Pharmaceutical committee which manages adverse drug effects		
Professional Affairs committee		
Quality committee (Quality Improvement committee)		
Risk Management committee		
Utilization committee		
Well-being committee		
Other (please specify)		

Options	Survey Result	Validation Result
Total number (#) of members		
Number (#) of committee members who are non-physician staff		
Number (#) of disciplines represented besides medicine (nursing, medicine, pharmacy, etc)		
Number (#) of different medical specialties represented(surgery, pediatrics, etc)		
Number (#) of committee members who are generalists		

Peer Review Survey
Data Validation Template

Organization # _____

What are the types of specialties that are represented on the committee? (check all that apply)

Options	Survey Result	Validation Result
Anesthesiology		
Emergency Medicine		
Family Practice		
IM subspecialty - Pediatric subspecialty		
Internal Medicine		
OB/Gynecology		
Psychiatry		
Radiology		
Surgery		
Pediatrics		

Schedule of committee meetings: How often does this peer review body meet?

Options	Survey Result	Validation Result
Monthly		
Quarterly		
Bi-weekly		
Bi-annually (every 6 months)		
Other		

Indicate the methods used in recruiting members to the Peer Review Body: (check all that apply)

Options	Survey Result	Validation Result
Payment is offered by organization		
Requirement for affiliation/employment		
Requirement for hospital privileges		
Experience in peer review		
Interest in peer review		
Willingness to serve		
Scheduled/rotating obligation		
Other Indicate 'other' methods:		
None of the above		

What is the usual term for each member who serves on the peer review body?

Options	Survey Result	Validation Result
1 year		
2 years		
More than 2 years		
Other (please specify term)		

Peer Review Survey
Data Validation Template

Organization # _____

Indicate responsibilities of the peer review body: (check all that apply)

Options	Survey Result	Validation Result
Quality of care concern (evaluate)		
Utilization of care (evaluate)		
Initial screening for patient care issue related to an organizational or systems-problem		
Initial screening for patient care issue related to a physician's practice		
Sentinel event		
A physician's practice pattern		
Series of complaints/events about physician		
Secondary or final determination of action, if any, to be taken for a patient care issue related to a physician's practice		
Tracking or monitoring of a physician's practice issue		
Submit an 805 report		
Submit an 821.5 report		
Convene or oversight of an 809 hearing		
Other If 'other' responsibilities, specify:		

Peer Review Survey
Data Validation Template

Organization # _____

In your organization, indicate circumstances or criteria for which an 805 or 821.5 report WOULD BE CONSIDERED: (check all that apply) A: INITIAL MECHANISMS in your organization by which potential 805 or 821.5 issues are identified: B: Criteria/circumstances used to determine whether an issue is taken to a SECONDARY or HIGHER LEVEL REVIEW body in your organization:

Reason	Survey Result		Validation Result	
	A Initial Mechanisms	B Secondary Review	A Initial Mechanisms	B Secondary Review
Patient complaint				
Multiple patient complaints				
Provider (mid-level/physician) complaint				
Multiple provider (mid-level/physician) complaints				
Nurse or other hospital employee complaint				
Multiple nurse or other hospital employee complaints				
Health plan complaint				
Multiple health plan complaints				
Quality program screening issue				
Utilization program screening issue				
Peer Review Committee screening issue required for the IPA, Health Plan membership, and/or hospital affiliation				
Risk management committee screening issue				
Provider practice pattern that is not consistent with the general standards of care				
Repeated allegations or errors in the delivery of care				
Potentially gross and flagrant care that endangers patient				
Egregious/sentinel event				
Malpractice case				
Arbitration/Mediation case				
Limitation or restriction of practice				
Required proctoring				
Other If 'other' criteria, specify and state for either scenario A or B above:				

Peer Review Survey
Data Validation Template

Organization # _____

Indicate the position of the person, committee, or mechanism that determines whether to refer an issue to a secondary or higher review body in the organization: (check all that apply)

Options	Survey Result	Validation Result
Chair of initial screening committee		
A majority vote of the initial screening committee		
Peer review chair		
Organization policies & procedures		
Medical Department Chair		
A majority vote of the Medical Department members		
Professional Affairs Committee decision		
Credentialing Committee decision		
Risk Management Committee decision		

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Appendix V: Federation of State Medical Board Documents

- The Special Committee on Evaluation of Quality of Care and Maintenance of Competence
- Trends in Physician Regulation, April 2006, Federation of State Medical Boards

The Special Committee on Evaluation of Quality of Care and Maintenance of Competence

Approved by the House of Delegates of the Federation of State Medical Boards of the United States, Inc., as policy May 1998
Revised Policy adopted by House of Delegates April 1999

Preamble

The Federation of State Medical Boards recognizes, as protectors of the public health and safety, state medical boards are accountable for the quality of health care provided by physicians within their jurisdictions as well as for assuring physician licensees are competent to practice medicine. To assist state medical boards in assuring standards of quality and competence within their jurisdictions, in April 1996, Federation President James E. West, MD, established the Special Committee on the Evaluation of Quality of Care and Maintenance of Competence.

The role of the state medical board in assuring quality of care and physician competence has increasingly become a major consumer issue, and therefore has gained the interest of the federal government. In February 1993, the U.S. Department of Health and Human Services, Office of the Inspector General, issued a report on state medical boards and their approaches to quality of care cases, wherein a variety of innovative approaches were identified. The report concluded that two factors are necessary in order for states to successfully handle quality of care cases: (1) adequate funding and (2) a serious and ongoing commitment to protect the public interest by actively addressing quality of care cases.1 As evidenced by the rising number of medical malpractice claims, negative media reports, legislative initiatives and criticisms of the overall health regulatory system, there appears to be a public perception that state medical boards could do a better job in handling quality of care cases and assuring ongoing medical competence.

The Special Committee on Evaluation of Quality of Care and Maintenance of Competence was charged with ③ evaluating and analyzing current procedures utilized by state medical boards in identifying and investigating complaints involving the quality of care rendered by a physician; ③ assessing the effectiveness of different approaches currently utilized by state medical boards to identify and investigate such complaints; ③ identifying sources of information/data which may be useful to medical boards in the evaluation of quality of care and maintenance of competence;

- ③ recommending to state medical boards methods to liaison with peer review groups, third party payors, PROs, etc., to enhance the boards' ability to evaluate complaints regarding quality of care as well as determining ongoing competence of physicians;
- ③ recommending enhanced methods of obtaining information and utilizing personnel in the evaluation of complaints regarding quality of care;
- ③ recommending the most effective/appropriate methods of investigating complaints regarding quality of care; and
- ③ recommending the most appropriate methods of assessing the continued competency of licensees.

In furtherance of its charge, the committee received presentations on innovative approaches for handling quality of care cases from several member medical boards and for physician assessment and evaluation. The committee also reviewed results of a survey of member medical boards regarding their processes for handling quality of care cases as well as pertinent reference materials.

The committee agreed prevention is integral to state medical boards' effectiveness in improving the quality of care provided to the public. State medical boards can improve the overall quality of care by

reducing problems in their physician population through preventive measures such as education, communication, and collaboration with other interested agencies and organizations.

Evaluation of Quality of Care and Maintenance of Competence

The Special Committee on Evaluation of Quality of Care and Maintenance of Competence

Section I. Definitions

For the purposes of its report, the committee has defined the following terms:
Assessment. A formal system to evaluate physician competence necessary to perform safely and effectively within the physician's scope of practice.

Competence. Possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of professional physician practice while adhering to professional ethical standards.

Dyscompetence. Failing to maintain acceptable standards in one or more areas of professional physician practice.

Incompetence. Lacking the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of professional physician practice.

Quality Care. The provision of health care services for individuals and populations that increase the likelihood of desired patient outcome(s) and are consistent with current professional knowledge and practice.

Remediation. The process whereby deficiencies in physician performance identified through an assessment system are corrected, resulting in an improved state of physician competence.

Section II. Identification

Recommendation One:
State medical boards should develop and implement methods to identify physicians who fail to provide quality care and therefore warrant further evaluation by the state medical board.

State medical boards are accountable to the public to assure physicians within their jurisdiction maintain a level of competence likely to ensure the delivery of health care consistent with current professional knowledge and practice. In order to achieve this public accountability, additional sources of information and data should be utilized in identifying physicians whose practice may warrant further evaluation.

Specifically, the committee recommends state medical boards

- ③ establish, expand and enforce statutory reporting requirements as specified in Section Xll, Compulsory Reporting and Investigation, A Guide to the Essentials of a Modern Medical Practice Act,2 and, if applicable, seek legislative authority to impose penalties for failure to report. Such requirements apply to physician licensees, other health care professionals, hospitals, medical societies, professional liability carriers, and third-party payors;
- ③ expand and/or clarify reporting requirements so information regarding physician quality of care issues, physician impairment, physician deselection from managed care participation, Medicare/Medicaid exclusions/restrictions, and loss/restriction of hospital privileges and/or medical staff memberships are reported to the state medical board together with the reasons therefor;
- ③ establish a liaison with state and local medical societies to educate and increase awareness among physicians of their professional obligation to report colleagues who fail to meet professional standards;
- ③ adopt a process for licensing or registering physicians enrolled in postgraduate training programs, based on the policy of the Federation of State Medical Boards3;
- ③ expand self-reporting by utilizing the reregistration process to gather information regarding changes in health status, continuing medical education, malpractice claims, judgments and/or settlements, specialty board certification status, changes in practice location, medical staff memberships and hospital privileges, and participation in health plans4; and
- ③ establish liaison committees with Peer Review Organizations (PRO) in order to utilize PRO performance and outcome data, and enhance the boards' ability to identify dyscompetent physicians, including the exchange of information related to any disciplinary actions taken against a licensee.

Recommendation Two:

States should enact mandatory reporting requirements and state medical boards should be provided the authority to impose penalties upon those individuals and institutions failing to comply with reporting requirements.

The disciplinary function of all state medical boards is primarily complaint driven. Therefore, a board's effectiveness in handling quality of care cases is enhanced by its ability to receive valid information from reliable sources.

The vast majority of complaints received by state medical boards are from the public. However, these complaints are less likely to result in formal board action or prosecution, especially as related to quality of care issues, than reports from physicians, other health care professionals, hospitals, professional societies, managed care organizations and insurers.

According to the FSMB 1995-1996 *Exchange, Section* 3, a comprehensive presentation of information regarding medical boards' structure and disciplinary functions, 46 boards have mandatory reporting requirements for all licensees, with only 23 boards having civil penalties for failing to report. Other health care professionals are only required to report in 12 jurisdictions. Hospitals, other health care provider entities (HMOs, IPPs, clinics), professional liability insurance carriers and medical professional societies are required to report possible medical practice act violations in many jurisdictions.4 In order to gain necessary and reliable information, states should enact mandatory reporting requirements and state medical boards should be provided the authority to impose penalties upon those individuals and institutions failing to comply with reporting requirements.

Recommendation Three:

State medical boards should develop and implement proactive methods of identifying the individual dyscompetent physician, as well as opportunities for improving physician practice in problematic areas.

Historically, the disciplinary function of state medical boards may be characterized as reactive. The committee suggests that measures to prevent breaches of professional conduct and improve physician practice will greatly enhance public protection. In order to proactively identify physicians who may be dyscompetent as well as to identify opportunities to improve physician practice, the committee suggests state medical boards

- ③ conduct random audits of pharmacy records to identify prescribing trends which indicate less than effective or obsolete therapies; ③ implement systems to effectively monitor prescribing of controlled substances to prevent inappropriate prescribing and/or drug diversion activities; ③ emphasize the importance of maintenance of clear and concise patient records through the issuance of guidelines, educational efforts and communications with licensees;
- ③ gather and utilize physician performance and outcome data received from sources such as PROs and managed care organizations, including entering into formal agreements to facilitate reporting of disciplinary actions involving a quality of care issue taken by a managed care organization against a licensed physician;5
- ③ develop a system of markers to identify licensees warranting evaluation, such markers to include, but not be limited to

a. o health status/age;
b. o number of complaints;
c. o number of malpractice claims/settlements/judgments;
d. o multiple and/or frequent changes in practice location;
e. o changes in area of practice without formal retraining;
f. o adverse actions by PROs, third-party payors;
g. o failure of specialty board recertification examination(s); and
h. o physician's whose practice is not subject to peer review by other entities, i.e., the physician with no affiliations to hospitals, clinics or managed care panels.

Section III: Evaluation and Investigation

Recommendation Four:
State medical boards should implement and utilize processes to enhance evaluation and investigation of cases wherein the quality of care rendered is in question.

The committee reviewed and evaluated the processes whereby state medical boards address complaints involving quality of care and identified elements the committee believed essential to the enhanced evaluation and investigation of quality of care cases. These elements included the employment of a physician acting as the board's medical director and employment of other health care professionals, inclusion of medical board members in the investigation process, and utilization of peer review panels.

To enhance the process whereby state medical boards evaluate and investigate cases involving quality of care issues, the committee suggests state medical boards

- ③ utilize the services of a staff or consultant medical director (MD/DO), preferably with medical board experience; ③ utilize individuals with health care experience and background as a part of the investigative team (e.g., nurses, physician assistants, advanced nurse practitioners);

- ③ utilize medical expertise in the evaluation and investigative process; and
- ③ utilize established practice guidelines.

Recommendation Five:
State medical boards should utilize a list of qualified physicians from which to select peer review panels in the evaluation and investigation of quality of care cases.
Peer review is essential to effective evaluation of quality of care cases, and state medical boards should encourage the voluntary participation of licensees as reviewers. The committee suggests state medical boards foster cooperative relationships with state and local medical societies and/or state PROs to secure available physician reviewers.

Recommendation Six:
State medical boards should develop and implement systems to efficiently process quality of care complaints. In order to best protect the public, complaints and reports involving quality of care issues must be processed in a timely and efficient manner. The committee suggests state medical boards develop a system to screen quality of care complaints and reports that incorporate complaint screening, determination of jurisdiction, categorization, and prioritization. Investigation of complaints should be conducted in the order of priority. All complaints recommended for closure after investigation should be reviewed by both public and professional members of the medical board.

The committee recommends, if appropriate, state medical boards conduct an informal conference with the physician to include selected members of the medical board, board attorney(s), investigators, and board support staff. The informal conference would provide a forum for the physician to be personally interviewed and provide additional information as to the circumstances, systems and practices which form the basis of the complaint(s).

Recommendation Seven:
State medical boards should broaden the scope of investigation beyond the incident report or complaint. The committee suggests, if deemed appropriate following screening, the investigation of quality of care cases not be limited to the incident (the subject of the complaint/report) and the investigation include, but not be limited to

- ③ a large sampling of patient records to identify a pattern of care;
- ③ office practices, systems and procedures;
- ③ performance/discharge data of hospitals, PROs and managed care organizations; and
- ③ interviews with colleagues, peers and patients.

Recommendation Eight:
State medical boards should review their Medical Practice Act and pursue legislative support for statutory language to validate the board's subpoena authority and provide the board access to external peer review records. To adequately protect patients, state medical boards should have subpoena authority to conduct comprehensive reviews of patient and physician office records. Additionally, it is critical state medical boards have administrative authority to access otherwise protected peer review records to determine if the physician whose performance is in question is likely to cause patient harm without board intervention.

Section IV: Disposition

Recommendation Nine:
Based upon investigative findings, state medical boards should utilize distinct disciplinary tracks in the disposition of quality of care cases.

The committee identified three tracks for disposition of cases involving quality of care issues.

- Track One. Cases in which no violation of the medical practice act was found, severity was determined to be low-level, and thereby the quality issue may be resolved either by closure, educational letter, conference or other means.
- Track Two. Cases where quality issues are present and indicate a likelihood of formal board action. Boards may utilize the full range of disciplinary action, including license revocation, restriction, probation and reprimand. Boards also may consider corrective action agreements, quality intervention plans, or other agreements requiring licensees to fulfill board mandated requirements for assessment and retraining.
- Track Three. Cases in which patient harm is imminent and emergency action by the medical board is warranted, including summary suspension, injunction and/or order for mental/physical examination/evaluation.

Section V: Assessment and Remediation

Recommendation Ten:
State medical boards should identify and utilize available means of physician assessment and remediation. Physician assessment and remediation are critical elements in assuring physician competence; state medical boards should utilize available programs offering assessment services and require dyscompetent physicians to participate in focused remediation programs. The committee encourages state medical boards to utilize the Federation's Special Purpose Examination (SPEX), or other examination as may become available and approved by the medical board. The SPEX may be a valuable assessment tool in that the examination is easily accessible to licensees and is offered via computer in approximately 220 testing sites throughout the United States and its territories.

On behalf of state medical boards, the Federation of State Medical Boards and the National Board of Medical Examiners have initiated a comprehensive national center for physician assessment of both cognitive skills and mental/physical impairments. This assessment will engage a series of evaluation tools including the SPEX or other similar computerized examination, computer-based case simulations and judgment analysis, and standardized patients. Following the assessment, the center will provide a report to the referring medical board with recommendations for remediation of the identified deficiencies.

Recommendation Eleven:
The Federation of State Medical Boards, on behalf of its member boards, should collaborate with other organizations to develop standards for programs offering remedial medical education.

In order to assure the quality and integrity of remedial medical education programs, standards must be developed to the satisfaction of state medical boards. Programs incorporating and complying with such standards could then be approved for referral of licensees. Additionally, the committee encourages state medical boards to initiate collaborative efforts with state medical societies, institutions offering medical education and training, and/or other medical professional organizations in supporting programs offering remedial medical education programs.

Section VI: Strategies to Enhance Quality of Care and Assure Maintenance

of Physician Competence

Recommendation Twelve:
State medical boards should develop programs to enhance overall physician practice.

As a means of ensuring continued physician competence, programs should be implemented to enhance overall physician practice in addition to disciplining individual physicians. The committee suggests the following preventive measures to enhance physician practice:

- ③ sponsor educational programs
- ③ share information regarding best practice and established practice guidelines
- ③ communicate to licensees in the form of newsletters or other means regarding recommendations for "best practice" in problematic areas, i.e., pain management, record keeping and boundary issues
- ③ collaborate with medical schools to educate students as to compliance with state laws governing the practice of medicine as well as professional ethical and boundary issues
- ③ establish a state-wide consortium consisting of the state medical board, medical professional societies, medical education programs, hospitals and health care organizations, and professional liability carriers, to sponsor medical educational opportunities to licensed physicians (continuing, focused and/or remedial)

Conclusion

State medical boards are ultimately accountable for the quality of care rendered within their jurisdictions and for the competence of those providing such care. Quality of care cases pose a particular challenge to state medical boards in that they are often difficult to define, require additional and often costly board resources, and, more than other breaches of professional conduct, require special medical and legal expertise in order to successfully prosecute. The effectiveness of state medical boards in these areas is dependent upon improving methods of processing quality of care cases, implementing measures to improve overall physician practice, and enhancing the competence of practicing physicians. To achieve this goal, it requires the continued commitment of medical board members and staff to improving the quality of health care amid changing health care settings.

References

1. 1. DHHS, Office of Inspector General. State medical boards and quality-of-care cases: promising approaches. February 1993.
2. 2. FSMB. A Guide to the Essentials of a Modern Medical Practice Act. April 1997.
3. 3. FSMB. Licensure of Physicians Enrolled in Postgraduate Training Programs. April 1996.
4. 4. FSMB. 1995-1996 Exchange. pp 38-39.
5. 5. FSMB. Special Committee on Managed Care (preliminary Recommendations).

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Trends in Physician Regulation

April 2006

Federation of STATE MEDICAL BOARDS

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Section 4: Upholding High Standards of Conduct

Overview

PUBLIC PROTECTION IN DIFFICULT TIMES

This report, *Trends in Physician Regulation,* provides in-depth looks at new developments in the work of state medical boards. It covers collaborations that served the public during the Hurricane Katrina crisis and that will help authorities mobilize large groups of physicians in the event of a national emergency. The report presents one example of how good policy makes for good medicine in the treatment of patients suffering chronic or end-of-life pain. The report also explores how boards are making their rich repositories of physician data available to consumers while balancing physicians' rights to due process and privacy. Finally, the report includes a state-by-state listing of disciplinary actions taken by medical boards during 2005. State medical boards are acting on these and other fronts in response to dramatic changes in the way physicians conduct their practices. A convergence of technical, social and economic forces are leading to these changes. Consider:

Rapid advances in technology and science are permanently changing the face of health care. The development of innovative medical products and procedures are improving the quality of life for many Americans, and even more exciting discoveries and developments are just over the horizon.These same advances are revolutionizing the practice of medicine. For example, telemedicine enables physicians to examine patients who live thousands of miles away. Physicians are increasingly mobile, with many doctors practicing in multiple states.

Patients are better informed and empowered. Patients have become much more active participants in their health care and demand accountability for the quality of care received.They come to their physicians with ideas and questions shaped by information readily accessible on the Internet and through other sources.

Health care costs are skyrocketing. The same advances in biomedicine and technology contributing to new products and procedures are resulting in steeply rising costs for health care. As advocates for their patients, physicians face complex challenges in balancing expensive state-of-the-art treatment with the value that such treatment will actually provide.At the same time, the public, employers and government at all levels are clamoring for relief from those costs.

As the state agencies authorized to protect the public from the incompetent and unethical practice of medicine, medical boards

are grappling with great challenges in this complex environment:

• How does a medical board regulate the practice of medicine that may involve a physician treating a patient – via robots and computers
– who is 2,000 miles away?
. • In a time when bioterrorism is a clear and present danger, how can medical boards help mobilize physicians with lightning speed to treat thousands of people potentially thousands of miles away?
. • In the age of the Internet, how do boards protect unwary patients from unethical physicians who prescribe dangerous drugs online without ever examining them?
. • How can boards work most effectively to help physicians translate new guidelines into practices that improve the quality of life of millions of people where it matters most: the patient?

Even as medical boards step up their activities to meet these challenges, they face increased pressure to improve the system for preventing incompetent, impaired and unethical physicians from doing harm. Medical boards receive their authority and funding through the states, the District of Columbia and the U.S. territories.Thus, they must compete with other state priorities for funding and staff.The level of authority and autonomy granted by the state also has a tremendous impact on their ability to carry out their vital work effectively.With all these forces at play, their task – overseen by volunteer physicians and technological advances, and even changing cultural attitudes toward community members who give countless hours – is a difficult one. It is medical practice. Examples include guidelines for pain management, also vital, arguably, never more so than during these days of change. standards for physician competence and the practice of medicine

via the Internet. The FSMB conducts research on these and other **About the Federation of State Medical Boards** issues; analyzes and develops policy; and serves as a resource for The Federation of State Medical Boards (FSMB) is a national not-for-policy makers, federal and state regulatory authorities, the health care profit organization representing the 70 medical boards of the United community, consumers and many others. On behalf of our members, States and its territories, including 14 state boards of osteopathic we are also providing leadership in collaborative efforts with other medicine. Our mission is to organizations to anticipate the changing needs of patients and their continuously improve the quality, safety and integrity of health care by developing and promoting high standards families where they intersect our work. It is in this spirit of supporting for physician licensure and practice.The FSMB helps our member our members in their service to the public that we present this report.

boards serve the public by continually updating and developing guidelines for regulation that reflect new medical knowledge,

We hope you find it useful, and we welcome your questions at *www.fsmb.org.*

Collaboration

MEDICAL BOARDS COLLABORATE TO PROTECT THE PUBLIC

The practice of medicine increasingly transcends state borders as physicians open multiple practice sites, provide consultations through satellite transmissions, and communicate with their patients and each other on the Internet. In one clear reflection of this trend, more than one in five practicing physicians now has a license in two or more jurisdictions.

This development holds tremendous promise for the public as individuals who live in underserved areas gain new access to health care and physicians in distant locations sit in on patient examinations or review scans and other medical information. In addition, concerns about the terrorist attacks of 2001 and the health care crisis created by Hurricane Katrina in 2005 focused new attention on the need to facilitate the movement of health care practitioners who want to provide services across jurisdictional boundaries.At the same time, this trend poses great challenges to state medical boards.While upholding each state's right to regulate medical practice within its borders, medical boards are working together to support physician mobility.The following is a review of progress made toward improving license portability, as well as a review of collaborative efforts by medical boards to facilitate the swift movement of physicians to help the public during large-scale health care emergencies.

Making Progress in License Portability

FSMB policies developed during the past decade call on state boards to adopt procedures that help physicians obtain licenses in multiple jurisdictions efficiently. Medical boards have made significant strides in establishing:

- a centralized system for primary source verification and storage of core physician credentials;
- a standardized medical license application and established standards for primary source verification of core credentials; and
- processes for expediting licensure if physicians meet certain qualifications, including full and unrestricted licensure in all jurisdictions where they hold a license and a clean disciplinary history.

System Enhancements Expedite Physician Licensure

Centralized System for Primary Source Verification

Established by the FSMB in 1996, the Federation Credentials Verification Service (FCVS) contains more than 60,000 physician profiles. Eleven medical boards now require FCVS profiles for licensure, and almost all medical licensing boards accept a FCVS profile to verify physicians' credentials.

At the request of a physician or physician assistant, FCVS keeps a permanent repository of verified "core" medical credentials, which include medical education, postgraduate training, examination history, board action history, board certification and identity. Modeled after the best practices of state medical boards, FCVS's standard credentialing parameters require the FSMB to verify core medical credentials directly with medical schools and postgraduate training programs. These verified credentials are immediately available at the request of the physician or physician assistant. This results in an expedited licensure process for the physician while reducing the

redundancies of the credentialing process and saving the physician and medical board staff time and money.

Standardizing the Licensure Application Process

In another advance, a task force of medical board representatives developed a Common License Application Form (CLA-F) in 2004 to reduce the amount of time and paperwork required to apply for licensure in multiple states.The CLA-F can serve as the core of a state's license application without replacing unique state-level requirements. Three state medical boards have now incorporated the CLA-F into their application processes. Both physicians and state medical boards benefit since the CLA-F reduces the number of incomplete applications, allows for the collection of uniform information and makes applications for licensure in multiple states more convenient.

Expedited Licensure Processes: Portability Demonstration Projects

Two regional groups of medical boards have been working to improve license portability through the design of demonstration projects. One collaboration has drawn together Maine, Massachusetts,Vermont, Connecticut, Rhode Island and New Hampshire in the northeastern United States, while the other has encompassed North Dakota, Kansas, Colorado, Minnesota, Iowa, Idaho and Oregon in the western United States.

Both groups seek to eliminate redundancies in their application processes. Although their plans differ, both call for a central database or interactive information system accessible to participating medical boards.The databases will contain printable digital image files, such as licensing applications, medical education and training credentials and examination transcripts, scanned in by participating boards. State boards will have immediate access to verified credentials, significantly reducing the time and paperwork required to issue a medical license. The federal government has appropriated initial funding for these multi-state projects through the FY 2006 Labor, Health and Human Services, Education Appropriations bill, signed into law in December 2005. Once additional funding is secured to implement the projects, the FSMB will play a central role by housing the core database and maintaining a Web-based service for data uploads by participating state medical boards.The FSMB anticipates additional state medical boards will commit to these efforts once the demonstration projects can show their feasibility and their benefits to a variety of stakeholders.


While upholding each state's right to regulate medical practice within its borders, medical boards are working together to support physician mobility.

Anticipated Benefits of License Portability Demonstration Projects

- Increasing access to medical services for patients in underserved areas
- Improving the ability to mobilize physicians during disasters
- Facilitating the mobility of physicians and multi-state practices
- Reducing barriers to telehealth across state lines
- Streamlining the license application process
- Decreasing redundancies associated with obtaining licensure in multiple states

Responding to Natural Disaster: State Medical Boards Collaborate During Hurricane Katrina Crisis

In August 2005, Hurricane Katrina swept across the Gulf Coast, leaving an enormous health care crisis in its wake and severely testing state medical licensure systems established to protect the public.An estimated 6,000 physicians were among the hundreds of thousands of Gulf Coast residents displaced to other states by the hurricane. Thousands of other physicians from across the country sought to enter the devastated region to help hurricane victims.This unprecedented dual migration of physicians created two major challenges for the region's medical boards:

. • How to expedite emergency licensure for displaced physicians so they could assist evacuated hurricane victims or begin practicing in new jurisdictions

. • How to verify the legitimacy of volunteer physicians seeking to help

in crisis areas Exacerbating the situation was the adverse effect of the hurricane on the Louisiana State Board of Medical Examiners.The board's offices were shut down for nearly six weeks, and all mechanisms for communications, including phone, fax, e-mail, cell phone and website, were unavailable.The catastrophe left the medical board with no means of verifying the legitimacy of either physicians coming into the devastated region or displaced Louisiana physicians seeking licensure in other states.

Developing Emergency Systems to Protect Patients

The FSMB and state medical boards quickly moved to address the situation. Using data the Louisiana medical board had provided to the FSMB's Physician Data Center just weeks before the hurricane, the FSMB created a Web-based, around-the-clock licensure verification system enabling state medical boards, disaster aid facilities and hospitals the ability to instantaneously verify licensure for

Louisiana physicians and physician assistants.

Operating throughout September 2005, this system made it possible to verify the licenses of more than 1,200 displaced physicians. The verification system also discouraged attempts from sanctioned and unlicensed individuals seeking to have their alleged license verifications forwarded to personal addresses. The crisis also created problems for medical boards in states contiguous to the disaster area, which began seeing sharp increases in licensure applications from Louisiana doctors as well as volunteer physicians from other states seeking to provide emergency assistance. By reducing their normal list of licensing requirements to several key elements, including disciplinary history to pinpoint physicians with sanction histories, medical boards in Texas and Mississippi were able to grant emergency licenses to displaced physicians quickly, usually within 24 hours.

Credentialing Displaced Physicians

Katrina destroyed educational and postgraduate training credentials of hundreds of Gulf Coast physicians and medical students.As they began seeking licensure in new states, medical boards contacted FCVS to help them locate missing credentials. If FCVS staff still came up empty handed, they tracked down previous hospital and/or managed care groups in which the physician had participated and been credentialed. FCVS eventually helped more than 125 physicians resume their practices through these efforts.

Contributing to Homeland Security: Medical Boards and the CDC Collaborate on Emergency Contact Information Database

In public health emergencies, lives depend on the ability of public health organizations at the federal, state and local levels to mobilize resources and mount coordinated responses quickly. In the wake of the attacks on Sept. 11, 2001, and subsequent isolated biological incidences, Congress directed the Centers for Disease Control and Prevention (CDC) to work with such organizations toward that goal.

One outgrowth of this directive has been a collaborative project between the CDC and the FSMB that calls for development of a complete database of emergency contact information for physicians practicing in the United States. Once completed, the database will allow the CDC to contact physicians immediately and provide critical information to them in the event of a terrorist attack or other public health emergency.

In 2004, the FSMB and the CDC embarked on a pilot program, in collaboration with seven medical boards in five states, to assess the feasibility of having state medical boards collect and maintain contact information for licensed physicians that could be used in times of emergency. Participants include the Maine Board of Licensure in Medicine, the Maine Board of Osteopathic Licensure, the North Dakota State Board of Medical Examiners, the Oklahoma State Board of Medical Licensure and Supervision, the Oklahoma Board of Osteopathic Examiners, the Rhode Island Board of Medical Licensure and Discipline, and the Virginia Board of Medicine.

Participating boards surveyed licensed physicians in their states to obtain contact information such as address, telephone number, e-mail address and fax number.The FSMB's Physician Data Center will house the collected data, and the CDC will be able to access the data during emergencies.The project will also put in place a mechanism for state and local health departments to notify physicians in the event of an emergency. Discussions are underway to expand the project to include states with high-density populations that are potential targets of terrorist attacks.

Pain Policy

STATES WORK FOR MORE CONSISTENT, APPROPRIATE PAIN MANAGEMENT

Despite major progress in the legitimate use of opioid analgesics to treat pain, a significant body of evidence suggests that both acute and chronic pain continue to be undertreated. Many terminally ill patients unnecessarily experience moderate to severe pain in the last weeks of life.

The persistence of undertreatment in both policy and practice has been attributed to social, economic, political, legal and educational

factors, including inconsistencies and restrictions in state pain policies. Circumstances that contribute to the prevalence of undertreated pain include:

. • lack of knowledge about medical standards, current research and clinical guidelines for appropriate pain treatment;
. • the perception that prescribing adequate amounts of controlled substances will result in unnecessary scrutiny by regulatory authorities;
. • misunderstanding of addiction and dependence; and
. • lack of understanding of regulatory policies and processes.

State medical boards recognize the undertreatment of pain as a serious public health problem that decreases patients' functional status and quality of life. In 2004, the FSMB continued its work to address this issue by adopting the *Model Policy for the Use of Controlled Substances for the Treatment of Pain*.This policy recognizes inadequate pain management as a continuing problem, as well as the obligation of government to develop a system that prevents abuse and diversion of controlled substances while ensuring their availability for legitimate medical purposes.
The *Model Policy* affirms that:

• state medical boards view pain management to be important and integral to the practice of medicine; • opioid analgesics may be necessary for the relief of pain;
. • the use of opioids for other than legitimate medical purposes poses a threat to the individual and society;
. • physicians have a responsibility to minimize the potential for the abuse and diversion of controlled substances; and
. • physicians will not be sanctioned solely for prescribing opioid analgesics for legitimate medical purposes.

The 2004 *Model Policy* builds on the landmark *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*. Adopted by the FSMB in 1998, the *Guidelines* sought to encourage effective pain management, to place such practice within the bounds of legitimate professional practice, to serve as an alternative to legislative action, and to encourage consistency among the states with respect to pain and controlled substances policy.

Prior to the mid-1990s, only a few states had pain management policy to guide their licensed physicians.As the science of prescribing medication for pain started to change, state medical boards saw a growing need to develop a framework that would guide physicians and assure the public of access to adequate treatment for pain.

In fact, the health care community as a whole widely embraced the 1998 *Model Guidelines* as a sensible, practical prescription for pain care. Several dozen state medical boards adopted the *Model Guidelines* in part or in entirety.The *Model Guidelines* also received the endorsement of the American Academy of Pain Medicine, the American Pain Society and the National Association of State Controlled Substances Authorities.

During the past decade, most state medical boards have revised or completely revamped their pain policies to reflect current knowledge in pain treatment.While this represents a significant advance toward more consistent and appropriate treatment of pain, the challenges are far from over. Many physicians continue to fear being investigated, or even arrested, for prescribing controlled substances for pain. Some physicians are also unaware of recent advances in our understanding of appropriate pain treatment. Complicating matters has been heightened sensitivity among federal regulators to the diversion of controlled substances for illicit uses.

The FSMB continues to encourage state medical boards to work with the attorney general in their state to identify regulatory restrictions blocking the effective use of controlled substances to relieve pain.

Promoting Appropriate Pain Management

In addition to developing or revising pain policies, the FSMB and a number of state medical boards have initiated national and state-level efforts to educate physicians and the public about appropriate management of pain. Following are several examples of these

educational efforts.

Publications

- The FSMB has distributed more than 300,000 copies of the *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* and the *Model Policy for the Use of Controlled Substances for the Treatment of Pain* since 1998 to state and federal legislators and other policymakers, state and federal regulators, physicians, medical professional organizations and patient advocacy groups. (The *Model* many sides to these difficult situations. (The *Facing Fears* video is *Policy* may be downloaded at www.fsmb.org.) available at www.fsmb.org.)


State medical boards recognize
the undertreatment of pain as a
serious public health problem.

. • The North Carolina Medical Board first adopted a statement on chronic, non-malignant pain a decade ago.The board revised the statement in 2005 when it adopted a modified version of the FSMB's *Model Guidelines*.The board's quarterly newsletter, *Forum*, frequently provides the state's physicians with the full texts of policies, as well as essays on pain management and related issues.The goal is to make sure physicians are comfortable using controlled substances to manage pain while preventing abuse of those substances. (For more information, visit ncmedboard.org.)

• In 2003, the University of Wisconsin Pain and Policy Studies Group (PPSG) released *Achieving Balance in State Pain Policy: A Progress Report Card*.The report evaluates how well state policies balance the medical availability of narcotic drugs with a system of controls to prevent abuse and diversion. (The report, which will be updated in June 2006, is available at www.medsch.wisc.edu/painpolicy.)

. • The Maryland Board of Physicians produced a video, *A Sense of Balance*, to educate physicians on controlled substances, chronic pain, over-prescribing medication, the addicted physician and identifying drug-seeking patients. (The video is available at mbp.state.md.us.)

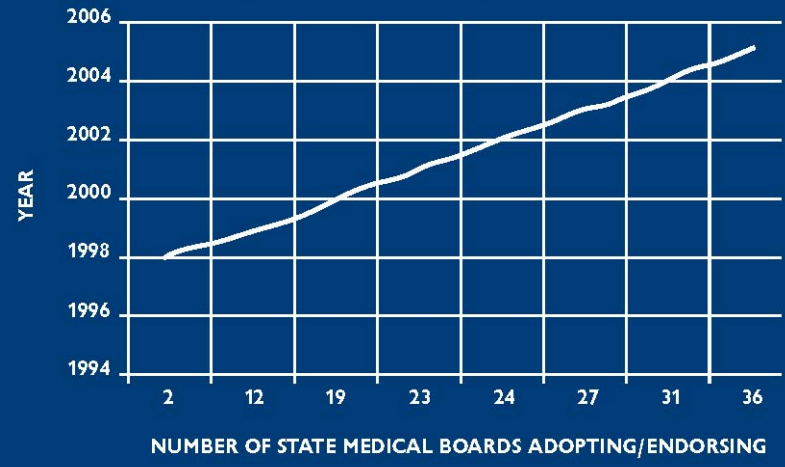
Multimedia

. • At the FSMB's 2003 Annual Meeting, a panel of physicians and regulators wrestled with issues surrounding the treatment of intractable pain and end-of-life pain. Moderated by Harvard Law School professor and television legal analyst Arthur Miller, J.D., the panel engaged in a Socratic dialogue around a series of challenging hypothetical situations involving patients with pain, where the right answer was not always clear. An educational video made from the session, *Facing Fears: Pain, Medication and End-of-Life Care*, shows the

Making Progress Against Pain Through Policy

Since the FSMB published the *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain* in May 1998, 36 state medical boards have adopted (in entirety or in part) or endorsed the *Model Guidelines* or the 2004 revision, *Model Policy*.

Cumulative Number of State Medical Boards Adopting/Endorsing FSMB Pain Management Guidelines/Policy, 1998-2005



Education

- The FSMB conducted a nationwide series of workshops on pain management in 2004-05 to help medical and pharmacy regulators encourage appropriate pain care in their jurisdictions, gain insights into new developments in pain treatment, and discuss regulatory responses to abuse and diversion of controlled substances.The series, “Promoting Balance and Consistency in the Regulatory Oversight of Pain Care,” attracted 350 participants representing 57 state medical boards, 21 state pharmacy boards and seven other organizations

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interested in pain care. (CDs of the FSMB pain workshops are available at www.fsmb.org.)

Joint Statements with Other Regulators

Physicians are not the only health care professionals struggling with the appropriate use of controlled substances to manage pain. Medical boards in Florida, Kansas, Minnesota, New Mexico, North Carolina and West Virginia have worked with other health care boards in their states to adopt joint statements on pain management and palliative care.

- In 2005, the boards of medicine, osteopathic medicine, nursing and pharmacy in both Florida and New Mexico adopted joint statements on pain management. After calling for physicians, nurses and pharmacists to cooperate in the appropriate treatment of pain, the Florida statement recognizes the need to monitor the prescribing of controlled substances for pain. The boards also sent a joint letter to Florida Gov. Jeb Bush recommending several steps the governor's office could take to prevent prescription drug abuse. Among the recommendations were the creation of an electronic reporting system for prescription drugs and a requirement that pharmacies see photo identification before filling prescriptions for controlled substances.
- In Minnesota, a joint statement adopted in 2004 by the boards of medicine, nursing and pharmacy calls for health care professionals to become and remain knowledgeable about effective pain management. The statement further urges practitioners to be aware of the risks of

Workshop Prompts Medical Board to Pursue Pai Management Legislation

The FSMB's workshop on appropriate pain management, "Promotin Balance and Consistency in the Regulatory Oversight of Pa Care," was influential in prompting Medical Board of Californ representatives to pursue amendments to laws that will improve pa treatment for patients and the regulation of physicians who tre pain patients. Legislation incorporating these changes, which h the potential to impact more than 100,000 physicians and tens thousands of patients, was introduced in February 2006.

Upholding High Standards of Conduct

STATE MEDICAL BOARDS: COMMITTED TO PUBLIC SAFETY

One important way state medical boards contribute to public safety is by ensuring physicians abide by acceptable standards of professional conduct. Increasingly, state medical boards are taking proactive measures that help to make the health care environment a safer one. These include:

. • using criminal background checks to identify physician licensure applicants with previously undisclosed criminal histories;
. • developing laws that prohibit the dangerous practice of prescribing drugs over the Internet solely on the basis of online questionnaires; and
. • proactively providing information about physicians to the public.

Medical Boards Conduct Criminal Background Checks

In response to evidence a small, but significant, cohort of physicians conceal criminal histories, medical boards are increasingly conducting criminal background checks on physicians who apply for licensure to practice medicine. In recent years, 27 state medical boards have been authorized to conduct criminal background checks. Nineteen of these boards are authorized to conduct national and state criminal background checks, while eight have authority to conduct state criminal background checks only.

Many state medical boards have access to their state's criminal record database, but they are not authorized to access national information through the Criminal History Record Information (CHRI) database, which includes data from the FBI's National Crime

Information Center. Federal law requires medical boards to obtain authority from their state legislatures before they can conduct criminal background checks on a national level, including the authority to gather fingerprints from physicians applying for or renewing a license. Once they have this authority, medical boards must collaborate with a law enforcement agency within their state to submit fingerprints to the CHRI database on behalf of the state medical board.

In January 2006, the FSMB conducted a survey of state medical boards that had implemented criminal background checks to gauge the effectiveness of such checks. Of the 16 states that responded, nine performed both state and federal criminal record checks, while seven only did state background checks.The survey revealed several significant trends:

. • On average, between two to five percent of physicians applying for licensure in one of the responding states had criminal histories.
. • Approximately one to three percent of physician applicants who had criminal histories did not report them on their applications.
. • The most common unreported crimes discovered by criminal background checks were driving under the influence and theft. Other unreported crimes included shoplifting, sex crimes, larceny, forged prescriptions, domestic violence, drug use/dealing/smuggling, assault and battery, trespassing, demonstrating, breaking and entering, child abuse, deportation, criminal mischief and murder.

In 2000, the Florida Board of Medicine reported approximately three percent of the physicians licensed after the board required fingerprinting showed a criminal history. Of the applicants with a criminal history, 44 percent failed to report criminal history information on their license application.

The FSMB survey indicated state medical boards made decisions on licensure applications from physicians with criminal background histories on a case-by-case basis. Most boards take into consideration the severity of the conviction and whether failure to disclose the criminal history was an honest oversight or a deliberate attempt practiced for 30 years and failed to report an arrest for participating in a protest while an undergraduate likely would not receive the same scrutiny as the doctor who “forgot” a DUI from the past year. Medical boards deny licensure to physician applicants with criminal histories when the nature of the conviction and other circumstances warrant. License denials are reported to the Federation Physician Data Center, managed by the FSMB, which medical boards routinely query when processing licensure applications.This system prevents physicians who have been denied licensure because of unrevealed criminal backgrounds in one state from concealing this past when applying for licensure in another

state. Other disciplinary actions taken by states against physicians with criminal histories include probation with specific warning.All of these actions are reportable to the Federation Physician Data Center.

Regulating ‘Rogue’ Internet Pharmacies

During the past several years, the proliferation of Internet pharmacy websites has posed a major challenge to medical regulators. Hundreds of these websites, known as “rogue” pharmacies, allow consumers to obtain prescription medications simply by filling out online health questionnaires.

These online pharmacies endanger the public because they do not require the standard physical examination crucial for correct diagnosis and treatment. Unwary consumers purchasing drugs from rogue sites run the risk of adverse drug reactions and/or interactions, misdiagnosis or delay in diagnosis, and failure to identify complicating conditions. Public health officials and media have documented a number of injuries and several fatalities attributable to medications obtained from rogue Internet pharmacies. Unwary consumers also have no way of knowing where the drugs on rogue sites originate and whether their manufacture has been regulated.

The temporal and far-flung nature of the Internet, with rogue websites opening and closing within days or even hours, presents complex challenges to state and federal regulators. In addition to the difficult task of identifying the physical location of Internet websites and the physicians who prescribe for them, regulators must simultaneously attempt to track numerous monitoring and enforcement actions against rogue pharmacies and physicians as they occur across multiple states.

State and Federal Efforts

State medical boards have pursued varied strategies on the state and federal levels to address the problem of rogue pharmacies.While physicians can certainly prescribe drugs over the Internet in the context of an appropriate relationship with their patients, more than 30 medical boards have developed statutes, rules or guidelines to regulate the practice; other boards have chosen to interpret existing laws to regulate online prescribing. Enforcement of these laws has led to disciplinary actions against physicians who write prescriptions for rogue Web pharmacies, with nearly 40 medical boards having taken action against physicians for the practice.The development of the *Model Guidelines for the Appropriate Use of the Internet in Medical Practice*, adopted by the FSMB's member boards in 2002, supports state medical boards as they develop policies or guidelines.

The National Clearinghouse on Internet Prescribing (NCIP), operated by the FSMB, also supports state efforts. Established in 2000 by the FSMB, the concept of the clearinghouse was supported by the Department of Justice, the Drug Enforcement Administration and the Food and Drug Administration, and initial funding was provided by several pharmaceutical firms.The NCIP purchases medications online to identify physicians and pharmacies associated with rogue pharmacy websites.The NCIP then distributes information obtained through its purchases to all affected state and federal regulatory agencies and files) complaints with state medical and pharmacy boards.To date, the NCIP has supported more than 210 investigations conducted by federal authorities and more than 450 investigations by state authorities, as well as work with several international agencies.

Federal legislation, introduced in 2005 with support from state medical boards, would lead to more effective regulation of rogue Internet pharmacies.The Ryan Haight Internet Pharmacy Consumer Protection Act would require Internet pharmacy websites to:

. • clearly identify the business, physician and pharmacist associated with the website;
. • prohibit a website from referring a customer to a doctor who then writes a prescription without ever seeing the patient; and
. • give state attorney generals the ability to shut down rogue websites nationwide, rather than just in their individual jurisdictions.

Physician Profiles Help Consumers Make Informed Health Care Choices

The demand for information on individual physicians has soared in recent years as increasingly empowered health care consumers seek to make informed decisions about their health care. In response, many health care organizations and for-profit firms have made “physician profiles” available to the public via the Internet. These profiles generally include data about physicians’ licensure status, education, medical specialties, disciplinary history and, in some cases, malpractice judgments. State medical boards have worked to make such information easily accessible through consumer-friendly physician profiles. Since Massachusetts became the first state to require physician profiles in 1996, nearly every state has begun offering them to the public.Twenty-three states have passed laws requiring their physician boards to provide profiles, while 42 medical boards have voluntarily done so.

The development of profiles builds on a long tradition among medical boards of making physician licensure and disciplinary data available to the public upon request. Because medical boards gather and verify information directly from physicians during the licensure process, the health care community generally views board profiles as the most accurate and up-to-date physician data available. Physician profiles do vary significantly. Profiles created by legislative mandate tend to be more comprehensive than those created by board initiative. Legislative enactments generally have required the inclusion of criminal convictions, medical malpractice information, and disciplinary actions by state medical boards and hospitals. The availability of technical resources can also impact the comprehensiveness of a board’s online profile. At a minimum, board profiles usually include licensure status and disciplinary history. More comprehensive profile systems may include full board orders of disciplinary actions and malpractice judgments. Most

profiles can be obtained via the Internet, and some boards offer the reports by telephone, mail and fax.

In order to make profile information more valuable to consumers, some boards add context to certain profile data to make it more meaningful. A special committee convened by the FSMB to study profiles found that although malpractice information is in great demand by consumers in evaluating physicians, such data is frequently not a reliable measure of a physician's competence. The committee's research found issues such as the physician's time in practice, the nature of their specialty, the types of patients treated and geographic location can significantly influence the number and amounts of malpractice judgments, awards and settlements. The committee's report sought to balance fairness to physicians with the need to facilitate public disclosure and protection. The report recommends malpractice profiles include:

1) the number of medical malpractice court judgments and arbitration awards against the physician within the past 10 years, and

2) the number of malpractice settlements when that number is equal to or exceeds three in the past 10 years. In addition, the report recommends profiles inform consumers that there is no conclusive evidence that malpractice data correlates with professional competence.

The FSMB also has created a national database that consolidates physician licensure and disciplinary information: the Federation Physician Data Center. For a nominal fee, consumers can log onto docinfo.org to learn whether a physician has been disciplined by any

U.S. medical board.The Physician Data Center contains more than 156,000 disciplinary actions against 46,000 physicians, dating from the 1960s.

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State Medical Boards and Public Protection

STATE MEDICAL BOARDS:AUTHORIZED TO PROTECT THE PUBLIC

The 10th Amendment of the United States Constitution authorizes states to establish laws and regulations protecting the health, safety and general welfare of their citizens. Medicine is a regulated profession because of the potential harm to the public if an incompetent or impaired physician is licensed to practice.To protect the public from the unprofessional, improper, unlawful,

fraudulent and/or incompetent practice of medicine, each of the 50 states, the District of Columbia, and the U.S. territories has a medical practice act that defines the practice of medicine and delegates the authority to enforce the law to a state medical board. State medical boards license physicians, investigate complaints, discipline those who violate the law, conduct physician evaluations and facilitate rehabilitation of physicians where appropriate. By following up on complaints, medical boards give the public a way to enforce basic standards of competence and ethical behavior in their physicians, and physicians a way to protect the integrity of their profession.There are currently 70 state medical boards authorized to regulate allopathic and osteopathic physicians.

Medical Board Structure

The structure and authority of medical boards vary from state to state. Some boards are independent and maintain all licensing and disciplinary powers, while others are part of a larger umbrella agency, such as a state department of health. State medical boards are typically made up of volunteer physicians and members of the public who are, in most cases, appointed by the governor and paid a nominal stipend for their service.The majority of state boards employ an administrative staff including an executive officer, attorneys, investigators and licensing staff. The state legislature determines the financial resources of most boards. Some boards are funded directly from physician licensing and registration fees.

Physician Licensure

Obtaining a license to practice medicine in the U.S. is a rigorous process. State medical boards ensure those entering the profession have met predetermined qualifications that include medical school graduation, postgraduate training, and passage of a national medical licensing examination.Applicants also must provide details about their work history and reveal information regarding past medical history that may affect their ability to practice.After physicians are licensed, they must re-register periodically to continue their active status. During this re-registration process, physicians must demonstrate that they have maintained acceptable standards of professional conduct and medical practice. In a majority of states, physicians must also show that they have participated in a program of continuing medical education.

Physician Discipline

Medical boards also monitor licensed physicians' competence and professional conduct.They review and investigate complaints and/or reports received from patients, health professionals, government agencies, health care organizations and other state medical boards about physicians who may be incompetent or acting unprofessionally, and take appropriate action against a physician's license if the person is found to have violated the law. State laws require that boards ensure fairness and due process to any physician under investigation.While medical boards sometimes find it necessary to suspend or revoke licenses, regulators have found many problems can be resolved with additional education or training in appropriate areas. In other instances, it may be more appropriate to place physicians on probation or place restrictions on a physician's license to practice. This compromise protects the public while maintaining a valuable community resource in the physician. Probation and restrictions of a medical license can also be in place while a physician receives further training or rehabilitation.

Federation of State Medical Boards
Summary of 2005 Board Actions

Each year, FSMB publishes electronically an *Annual Summary* of Board Actions, a compilation of disciplinary actions initiated by its 70 member boards. In addition to providing disciplinary data, the report includes information about the context within which each medical board operates, including the standards of proof required of each board when prosecuting cases and the health care professions regulated by each board.

The *Annual Summary* is most useful to track trends in physician discipline within each state. Comparisons or rankings across states are not useful as states operate with different financial resources, levels of autonomy, legal constraints and staffing levels.

The report includes disciplinary data for each board from 2001-05. During this five-year period, the total number of actions taken by medical boards rose from 4,662 in 2001 to 6,213 in 2005.

In addition to disciplinary data and board information, the report includes the Composite Action Index. Designed by FSMB, the CAI is a tool that assists state medical boards in evaluating their performance over time. The CAI calculation is a weighted average of disciplinary actions taken against physicians practicing in a state, as well as all physicians licensed by that state. Actions affecting physicians' licenses, such as revocations and suspensions, are weighted more heavily in a state's CAI.

Please note the validity of the CAI is limited in states that have total in-state physician licensee populations of less than 1,000.

Summary of Board Actions Definitions

Loss of License or Licensed Privilege: Includes revocation, suspension, surrender or mandatory retirement of license or loss of privileges afforded by that license.

Restriction of License or Licensed Privilege: Includes probation, limitation, or restriction of license or licensed privileges.

Other Prejudicial Actions: Modification of a physician's license, or the privileges granted by that license, that results in a penalty or reprimand, etc., to the physician. Such action is specific to the individual physician as opposed to a group of physicians (example: denial of a license due to adverse information concerning an individual as opposed to a denial based on lack of qualification that would apply to a large group of people).

Non-prejudicial Actions: An action that does not result in modification or termination of a license or licensed privileges. This action is frequently administrative in nature, such as a license denial due to lack of qualification or a reinstatement following disciplinary action.

Number of Physicians with Prejudicial Actions: This number refers to the total number of individual physicians against whom prejudicial actions have been taken within a jurisdiction. Because an individual physician may have two or more prejudicial actions, this number usually is less than the total number of prejudicial actions taken within a jurisdiction. Because some physicians hold licenses in more than one state, a total would not be an accurate reflection of the total number of physicians with prejudicial actions in the country because many physicians may have received prejudicial actions in all of the states where they hold a license.

Number of Physicians with Non-prejudicial Actions: This number refers to the total number of individual physicians against whom non-prejudicial actions have been taken within a jurisdiction. Because an individual physician may have two or more non-prejudicial

reflection of the total number of physicians with non-prejudicial actions in the country because many physicians may have received non-prejudicial actions in all of the states where they hold a license. **Total Number of Physicians with Actions:** This number refers to the total number of individual physicians against whom any type of actions have been taken within a jurisdiction. This number is not always equal to the sum of physicians with prejudicial and physicians with non-prejudicial actions, because an individual physician receiving both a prejudicial and a non-prejudicial action in a jurisdiction is not counted twice. Because some physicians hold licenses in more than one state, a total would not be an accurate reflection of the total number of physicians with actions in the country because many physicians may have received actions in all of the states where they hold a license. **Total Number of Licensed Physicians:** Refers to the total number of physicians who have been licensed to practice within a specific jurisdiction. Because not all physicians who are licensed to practice within a jurisdiction actually practice within that jurisdiction, this number is usually greater than the Number of Physicians Practicing Instate. Because some physicians hold licenses in more than one state, a total would not be an accurate reflection of the total number of licensed physicians in the country because many physicians would be counted more than once.

Total Number of Licensed Physicians Practicing In-State:

Refers to the total number of physicians who are actually practicing within a specific jurisdiction. Because not all physicians who are licensed to practice within a jurisdiction actually practice within that jurisdiction, this number is usually less than the Total Number of Licensed Physicians. **Composite Action Index:** The Composite Action Index (CAI) assists state medical boards in monitoring their disciplinary activity over time. It is not designed to be used in comparing boards to one another. The CAI is a weighted average of disciplinary actions taken against physicians practicing in a state, as well as all physicians licensed by a state. Actions affecting physicians' licenses, such as revocations and suspensions, are weighted more heavily in computing a state's CAI.

How the CAI is computed:

1. **1.** A board's total number of actions is divided by the total number of licensed physicians in a state.
2. **2.** A board's total number of actions is divided by the total number of physicians practicing in the state.

3. **3.** A board's total number of prejudicial actions is divided by the total number of physicians licensed by the state, whether they practice in the state or not.
4. **4.** A board's total number of prejudicial actions is divided by the total number of physicians practicing in the state.

A state medical board's CAI is determined by the average of lines one through four. Lines three and four are weighted more heavily to reflect the more serious nature of prejudicial actions.

Professions Regulated by a Board:

ACU-acupuncturist;ANA-anesthetist assistant;AT-athletic trainer; AUD-audiologist; BLD-biological lab director; CHI-chiropractor; CIS-cardiovascular invasive specialist; CP-clinical perfusionist; CT-cosmetic therapist; DEH-dental hygienist; DEI-dietician; DO-osteopathic physician; ELE-electrologist; EMT-emergency medical technician; HAD-hearing aid dispenser; ICU-mobile intensive care unit; MA-medical assistant; MC-medical corporation; MD-allopathic physician; MR-medical resident; MP-medical physicist; MR-medical resident; MT-message therapist; NA-nurse anesthetist; NAT-naturopath; NM-nurse midwife; NP-nurse practitioner; NUT-nutritionist; OT-occupational therapist; OP-optometrist; OTA-occupational therapist assistant; PA-physician assistant; PAC-physician assistant corporation; PER-perfusionist; PT-physical therapist; PTA-physical therapist assistant; POD-podiatrist; RN-registered nurse; RT-respiratory therapist; RT-radiological technologist; RTL-radiological technologists limited; SA-surgical assistant; SL-speech language pathologist; SLA-speech language pathologist assistant.

State Medical Board Disciplinary Reports

Summary of 2005 Board Actions

Alabama State Board of Medical Examiners

P.O. BOX 946

Summary of 2005 Board Actions

Alaska State Medical Board

550 West Seventh Ave, Suite 1500

Montgomery, AL 36104
http://www.albme.org
(334) 242-4116; Fax: (334) 242-4155

Board Information

Board Size/Composition	15 / 15 MD
Board Meeting Frequency	Monthly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, DO, PA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	68	53	78	75	78
Loss of License or Licensed Privilege	25	18	33	34	33
Restriction of License or Licensed Privilege	13	19	13	18	14
Other Prejudicial Actions	20	6	22	14	20
Total Prejudicial Actions	58	43	68	66	67
Non-Prejudicial Actions	10	10	10	9	11
Number of Physicians with Prejudicial Actions	47	41	60	55	60
Number of Physicians with Non-Prejudicial Actions	12	10	10	9	11
Total Number of Physicians with Actions	55	49	67	62	68

Physician Population					
Total Number of Licensed	14,423	14,113	13,828	13,781	13,716

Anchorage, AK 99501
http://www.dced.state.ak.us/occ/pmed.htm
(907) 269-8163; Fax: (907) 269-8196

Board Information

Board Size/Composition	8 / 5 MD, 2 public, 1 other
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, POD, ICU

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	32	23	20	24	19
Loss of License or Licensed Privilege	16	9	10	8	8
Restriction of License or Licensed Privilege	3	3	1	5	3
Other Prejudicial Actions	12	9	5	10	7
Total Prejudicial Actions	31	21	16	23	18
Non-Prejudicial Actions	1	2	4	1	1
Number of Physicians with Prejudicial Actions	29	20	15	19	18
Number of Physicians with Non-Prejudicial Actions	1	2	4	1	1
Total Number of Physicians with Actions	29	22	19	20	19

Physician Population					
Total Number of Licensed	2,756	2,406	2,540	2,244	2,292

Physicians						Physicians					
Total Number of Licensed Physicians Practicing In-State	9,955	9,746	9,431	9,342	9,177	Total Number of Licensed Physicians Practicing In-State	1,516	1,430	1,447	1,366	1,330
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	4.71	3.76	5.64	5.44	5.69	Total Actions/Total Licensed Physicians	11.61	9.56	7.87	10.70	8.29
Total Actions/Practicing In-State Physicians	6.83	5.44	8.27	8.03	8.50	Total Actions/Practicing In-State Physicians	21.11	16.08	13.82	17.57	14.29
Total Prejudicial Actions/Total Licensed Physicians	4.02	3.05	4.92	4.79	4.88	Total Prejudicial Actions/Total Licensed Physicians	11.25	8.73	6.30	10.25	7.85
Total Prejudicial Actions/Practicing In-State Physicians	5.83	4.41	7.21	7.06	7.30	Total Prejudicial Actions/Practicing In-State Physicians	20.45	14.69	11.06	16.84	13.53
Composite Action Index	5.35	4.16	6.51	6.33	6.59	Composite Action Index	16.10	12.26	9.76	13.84	10.99

Summary of 2005 Board Actions

Arizona Medical Board

9545 E Doubletree Ranch Rd
Scottsdale, AZ 85258-5539
http://www.azmd.gov
(480) 551-2700; Fax: (480) 551-2704

Board Information

Board Size/Composition	12 / 8 MD, 4 public
Board Meeting F	Bimonthly

Summary of 2005 Board Actions

Arizona Board of Osteopathic Examiners in Medicine and Surgery

9535 East Doubletree Ranch Road
Scottsdale, AZ 85258-5539
http://www.azosteoboard.org
(480) 657-7703; Fax: (480) 657-7715

Board Information

Board Size/Composition	7 / 5 DO, 2 public
Board Meeting F	8 per year

Frequency Standard of Proof Required Professions Regulated by Board	Preponderance of the Evidence MD				
Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	119	101	166	157	186
Loss of License or Licensed Privilege	33	17	37	18	32
Restriction of License or Licensed Privilege	48	46	66	71	92
Other Prejudicial Actions	32	28	37	32	44
Total Prejudicial Actions	113	91	140	121	168
Non-Prejudicial Actions	6	10	26	36	18
Number of Physicians with Prejudicial Actions	97	83	119	101	143
Number of Physicians with Non-Prejudicial Actions	7	11	30	38	18
Total Number of Physicians with Actions	101	90	142	127	151
Physician Population					
Total Number of Licensed Physicians	17,832	17,226	16,551	15,882	15,299
Total Number of Licensed Physicians Practicing In-State	11,673	11,175	10,583	10,206	9,803
Composite Action Index					
Total Actions/Total Licensed Physicians	6.67	5.86	10.03	9.89	12.16
Total Actions/Practicing In-State Physicians	10.19	9.04	15.69	15.38	18.97

Frequency Standard of Proof Required Professions Regulated by Board	Preponderance of the Evidence DO				
Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	22	19	10	12	39
Loss of License or Licensed Privilege	4	6	5	0	12
Restriction of License or Licensed Privilege	5	7	4	6	12
Other Prejudicial Actions	5	1	0	1	9
Total Prejudicial Actions	14	14	9	7	33
Non-Prejudicial Actions	8	5	1	5	6
Number of Physicians with Prejudicial Actions	13	10	8	5	22
Number of Physicians with Non-Prejudicial Actions	8	5	1	5	8
Total Number of Physicians with Actions	19	15	9	10	27
Physician Population					
Total Number of Licensed Physicians	1,960	1,871	1,779	1,632	1,674
Total Number of Licensed Physicians Practicing In-State	1,427	1,367	1,426	1,171	1,118
Composite Action Index					
Total Actions/Total Licensed Physicians	11.22	10.15	5.62	7.35	23.30
Total Actions/Practicing In-State Physicians	15.42	13.90	7.01	10.25	34.88

Total Prejudicial Actions/Total Licensed Physicians	6.34	5.28	8.46	7.62	10.98
Total Prejudicial Actions/Practicing In-State Physicians	9.68	8.14	13.23	11.86	17.14
Composite Action Index	8.22	7.08	11.85	11.19	14.81

Total Prejudicial Actions/Total Licensed Physicians	7.14	7.48	5.06	4.29	19.71
Total Prejudicial Actions/Practicing In-State Physicians	9.81	10.24	6.31	5.98	29.52
Composite Action Index	10.90	10.44	6.00	6.97	26.85

Summary of 2005 Board Actions

Arkansas State Medical Board

2100 Riverfront Drive
Little Rock, AR 72202-1793
http://www.armedicalboard.org
(501) 296-1802; Fax: (501) 603-3555

Board Information

Board Size/Composition	13 / 10 MD, 1 DO, 2 public
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, RT, OT, OT-A

Board Actions	2005	2004	2003	2002	2001
Total Actions	36	23	26	26	41
Loss of License or Licensed Privilege	18	5	9	13	18

Summary of 2005 Board Actions

Medical Board of California

1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
http://www.caldocinfo.ca.gov
(916) 263-2389; Fax: (916) 263-2387

Board Information

Board Size/Composition	21 / 12 MD, 9 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD

Board Actions	2005	2004	2003	2002	2001
Total Actions	624	651	572	569	495
Loss of License or Licensed Privilege	218	216	204	189	166

Restriction of License or Licensed Privilege	8	4	4	6	7	Restriction of License or Licensed Privilege	145	159	166	138	127
Other Prejudicial Actions	9	13	10	5	6	Other Prejudicial Actions	155	169	116	119	114
Total Prejudicial Actions	35	22	23	24	32	Total Prejudicial Actions	518	544	486	446	407
Non-Prejudicial Actions	1	1	3	2	9	Non-Prejudicial Actions	106	107	86	123	88
Number of Physicians with Prejudicial Actions	23	21	21	21	25	Number of Physicians with Prejudicial Actions	427	449	402	374	346
Number of Physicians with Non-Prejudicial Actions	1	1	3	2	11	Number of Physicians with Non-Prejudicial Actions	103	106	88	123	87
Total Number of Physicians with Actions	23	21	23	22	29	Total Number of Physicians with Actions	504	531	469	469	414
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	8,183	8,156	8,123	8,038	7,830	Total Number of Licensed Physicians	120,436	118,656	116,331		113,208 110,800
Total Number of Licensed Physicians Practicing In-State	5,510	5,404	5,330	5,196	5,128	Total Number of Licensed Physicians Practicing In-State	93,501	91,936	90,019	88,149	86,071
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	4.40	2.82	3.20	3.23	5.24	Total Actions/Total Licensed Physicians	5.18	5.49	4.92	5.03	4.47
Total Actions/Practicing In-State Physicians	6.53	4.26	4.88	5.00	8.00	Total Actions/Practicing In-State Physicians	6.67	7.08	6.35	6.45	5.75
Total Prejudicial Actions/Total Licensed Physicians	4.28	2.70	2.83	2.99	4.09	Total Prejudicial Actions/Total Licensed Physicians	4.30	4.58	4.18	3.94	3.67
Total Prejudicial Actions/Practicing In-State Physicians	6.35	4.07	4.32	4.62	6.24	Total Prejudicial Actions/Practicing In-State Physicians	5.54	5.92	5.40	5.06	4.73
Composite Action Index	5.39	3.46	3.81	3.96	5.89	Composite Action Index	5.42	5.77	5.21	5.12	4.66

Summary of 2005 Board Actions

Osteopathic Medical Board of California

2720 Gateway Oaks Dr, Suite 350
Sacramento, CA 95833-3500
http://www.dca.ca.gov/osteopathic
(916) 263-3100; Fax: (916) 263-3117

Board Information

Board Size/Composition	7 / 5 DO, 2 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	DO

Board Actions	2005	2004	2003	2002	2001
Total Actions	23	23	29	16	18
Loss of License or Licensed Privilege	3	7	10	4	5
Restriction of License or Licensed Privilege	11	7	11	6	4
Other Prejudicial Actions	7	7	4	4	5
Total Prejudicial Actions	21	21	25	14	14
Non-Prejudicial Actions	2	2	4	2	4
Number of Physicians with Prejudicial Actions	16	19	24	13	13

Summary of 2005 Board Actions

Colorado Board of Medical Examiners

1560 Broadway, Suite 1300
Denver, CO 80202-5140
http://www.dora.state.co.us/medical/
(303) 894-7690; Fax: (303) 894-7692

Board Information

Board Size/Composition	13 / 7 MD, 2 DO, 4 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA

Board Actions	2005	2004	2003	2002	2001
Total Actions	153	146	124	155	101
Loss of License or Licensed Privilege	30	39	34	49	32
Restriction of License or Licensed Privilege	54	43	37	44	25
Other Prejudicial Actions	44	49	35	38	36
Total Prejudicial Actions	128	131	106	131	93
Non-Prejudicial Actions	25	15	18	24	8
Number of Physicians with Prejudicial Actions	112	115	88	115	89

Number of Physicians with Non-Prejudicial Actions	2	3	4	2	4	Number of Physicians with Non-Prejudicial Actions	29	15	20	25	8
Total Number of Physicians with Actions	18	20	27	15	17	Total Number of Physicians with Actions	130	127	102	132	95
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	4,389	4,128	3,798	3,557	3,330	Total Number of Licensed Physicians	15,172	15,285	16,619	14,020	12,953
Total Number of Licensed Physicians Practicing In-State	3,089	2,831	2,590	2,362	2,168	Total Number of Licensed Physicians Practicing In-State	11,876	11,710	11,178	10,688	10,077
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	5.24	5.57	7.64	4.50	5.41	Total Actions/Total Licensed Physicians	10.08	9.55	7.46	11.06	7.80
Total Actions/Practicing In-State Physicians	7.45	8.12	11.20	6.77	8.30	Total Actions/Practicing In-State Physicians	12.88	12.47	11.09	14.50	10.02
Total Prejudicial Actions/Total Licensed Physicians	4.78	5.09	6.58	3.94	4.20	Total Prejudicial Actions/Total Licensed Physicians	8.44	8.57	6.38	9.34	7.18
Total Prejudicial Actions/Practicing In-State Physicians	6.80	7.42	9.65	5.93	6.46	Total Prejudicial Actions/Practicing In-State Physicians	10.78	11.19	9.48	12.26	9.23
Composite Action Index	6.07	6.55	8.77	5.28	6.09	Composite Action Index	10.55	10.44	8.60	11.79	8.56

Summary of 2005 Board Actions

Connecticut Medical Examining Board

P.O. BOX 340308

Hartford, CT 06134-0308

http://www.dph.state.ct.us

Summary of 2005 Board Actions

District of Columbia Board of Medicine

717 14TH Street, NW Suite 600

Washington, DC 20005

http://dchealth.dc.gov

(860) 509-7648; Fax: (860) 509-7553

(202) 724-4900; Fax: (202) 727-8471

Board Information	
Board Size/Composition	15 / 8 MD, 1 DO, 1 PA, 5 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	69	50	49	53	42
Loss of License or Licensed Privilege	13	15	20	20	13
Restriction of License or Licensed Privilege	23	16	19	12	13
Other Prejudicial Actions	33	19	9	13	7
Total Prejudicial Actions	69	50	48	45	33
Non-Prejudicial Actions	0	0	1	8	9
Number of Physicians with Prejudicial Actions	67	45	42	40	29
Number of Physicians with Non-Prejudicial Actions	0	0	1	8	9
Total Number of Physicians with Actions	67	45	42	47	38

Physician Population					
Total Number of Licensed Physicians	15,033	14,721	14,463	13,424	13,591
Total Number of Licensed Physicians Practicing In-State		11,196	11,050	10,421	10,583

Board Information	
Board Size/Composition	11 / 8 MD, 3 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, ACU, PA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	17	17	15	16	6
Loss of License or Licensed Privilege	7	6	8	10	3
Restriction of License or Licensed Privilege	4	7	4	4	1
Other Prejudicial Actions	4	2	3	1	0
Total Prejudicial Actions	15	15	15	15	4
Non-Prejudicial Actions	2	2	0	1	2
Number of Physicians with Prejudicial Actions	14	13	14	13	4
Number of Physicians with Non-Prejudicial Actions	3	2	0	1	2
Total Number of Physicians with Actions	16	14	14	13	6

Physician Population					
Total Number of Licensed Physicians	9,076	8,319	9,374	9,609	9,292
Total Number of Licensed Physicians Practicing In-	2,727	5,473	4,688	6,649	4,646

11,455						State					
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	4.59	3.40	3.39	3.95	3.09	Total Actions/Total Licensed Physicians	1.87	2.04	1.60	1.67	0.65
Total Actions/Practicing In-State Physicians	6.02	4.47	4.43	5.09	3.97	Total Actions/Practicing In-State Physicians	6.23	3.11	3.20	2.41	1.29
Total Prejudicial Actions/Total Licensed Physicians	4.59	3.40	3.32	3.35	2.43	Total Prejudicial Actions/Total Licensed Physicians	1.65	1.80	1.60	1.56	0.43
Total Prejudicial Actions/Practicing In-State Physicians	6.02	4.47	4.34	4.32	3.12	Total Prejudicial Actions/Practicing In-State Physicians	5.50	2.74	3.20	2.26	0.86
Composite Action Index	5.31	3.93	3.87	4.18	3.15	Composite Action Index	3.82	2.42	2.40	1.97	0.81

Summary of 2005 Board Actions

Delaware Board of Medical Practice

P.O. BOX 1401
Dover, DE 19903
http://www.dpr.delaware.gov
(302) 739-4522; Fax: (302) 739-2711

Board Information

Board Size/Composition	16 / 10 MD, 1 DO, 5 public
Board Meeting Frequency	10 per year
Standard of Proof Required	Preponderance of the Evidence

Summary of 2005 Board Actions

Florida Board of Medicine

Department Of Health

4052 Bald Cypress Way, BIN#C06
Tallahassee, FL 32399-3253
http://www.doh.state.fl.us
(850) 245-4131; Fax: (850) 488-9325

Board Information

Board Size/Composition	15 / 12 MD, 3 public
Board Meeting Frequency	Bimonthly

Professions Regulated by Board	MD, DO, PA, RT, EMT

Board Actions	2005	2004	2003	2002	2001
Total Actions	5	4	6	5	2
Loss of License or Licensed Privilege	1	2	3	1	2
Restriction of License or Licensed Privilege	3	2	1	2	0
Other Prejudicial Actions	1	0	2	1	0
Total Prejudicial Actions	5	4	6	4	2
Non-Prejudicial Actions	0	0	0	1	0
Number of Physicians with Prejudicial Actions	4	4	6	4	2
Number of Physicians with Non-Prejudicial Actions	0	0	0	1	0
Total Number of Physicians with Actions	4	4	6	5	2
Physician Population					
Total Number of Licensed Physicians	4,105	4,174	3,690	3,539	3,452
Total Number of Licensed Physicians Practicing In-State	2,170		1,111		1,970

Composite Action Index

Standard of Proof Required	Clear and Convincing Evidence
Professions Regulated by Board	MD, PA, DEI, ANA, ELE

Board Actions	2005	2004	2003	2002	2001
Total Actions	901	976	410	320	381
Loss of License or Licensed Privilege	137	111	75	67	90
Restriction of License or Licensed Privilege	45	42	37	28	43
Other Prejudicial Actions	690	794	278	198	222
Total Prejudicial Actions	872	947	390	293	355
Non-Prejudicial Actions	29	29	20	27	26
Number of Physicians with Prejudicial Actions	815	913	371	264	318
Number of Physicians with Non-Prejudicial Actions	37	30	20	27	26
Total Number of Physicians with Actions	834	930	388	282	338
Physician Population					
Total Number of Licensed Physicians	53,556	49,448	48,890	47,955	48,004
Total Number of Licensed Physicians Practicing In-State	38,216	36,976	45,061	44,573	41,505

Total Actions/Total Licensed Physicians	1.22	0.96	1.63	1.41	0.58
Total Actions/Practicing In-State Physicians	2.30		5.40		1.02
Total Prejudicial Actions/Total Licensed Physicians	1.22	1.63	0.58	0.96	1.13
Total Prejudicial Actions/Practicing In-State Physicians	2.30		5.40		1.02
Composite Action Index	1.76		3.51		0.80

Composite Action Index

Total Actions/Total Licensed Physicians	16.82	19.74	8.39	6.67	7.94
Total Actions/Practicing In-State Physicians	21.71	25.54	11.09	7.10	8.55
Total Prejudicial Actions/Total Licensed Physicians	16.28	19.15	7.98	6.11	7.40
Total Prejudicial Actions/Practicing In-State Physicians	21.01	24.78	10.55	6.50	7.96
Composite Action Index	18.96	22.30	9.50	6.60	7.96

Summary of 2005 Board Actions

Florida Board of Osteopathic Medicine

4052 Bald Cypress Way, Bin C06
Tallahassee, FL 32399-1753
http://www.doh.state.fl.us/mqa/osteopath/os_home.html
(850) 245-4161; Fax: (850) 487-9874

Board Information

Board Size/Composition	7 / 5 DO, 2 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Clear and Convincing Evidence
Professions Regulated by Board	DO

Summary of 2005 Board Actions

Georgia Composite State Board of Medical Examiners

2 Peachtree Street, NW 36TH Floor
Atlanta, GA 30303
http://www.medicalboard.state.ga.us
(404) 656-3913; Fax: (404) 656-9723

Board Information

Board Size/Composition	14 / 10 MD, 2 DO, 1 public, 1 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by	MD, DO, ACU, PA, RT, PER

Board											
Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**	**Board Actions**	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	32	71	50	49	39	Total Actions	156	174	163	129	137
Loss of License or Licensed Privilege	6	15	11	7	4	Loss of License or Licensed Privilege	45	48	43	34	38
Restriction of License or Licensed Privilege	7	4	9	4	3	Restriction of License or Licensed Privilege	36	37	47	51	56
Other Prejudicial Actions	17	47	28	35	25	Other Prejudicial Actions	52	69	55	28	12
Total Prejudicial Actions	30	66	48	46	32	Total Prejudicial Actions	133	154	145	113	106
Non-Prejudicial Actions	2	5	2	3	7	Non-Prejudicial Actions	23	20	18	16	31
Number of Physicians with Prejudicial Actions	27	62	41	44	28	Number of Physicians with Prejudicial Actions	123	135	133	92	81
Number of Physicians with Non-Prejudicial Actions	2	5	2	3	7	Number of Physicians with Non-Prejudicial Actions	24	24	20	20	38
Total Number of Physicians with Actions	28	64	43	46	33	Total Number of Physicians with Actions	143	154	149	106	108
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	4,598	4,275	4,257	4,039	3,953	Total Number of Licensed Physicians	27,529	26,262	25,659	25,518	25,808
Total Number of Licensed Physicians Practicing In-State	3,474	3,328	3,116	3,325	2,631	Total Number of Licensed Physicians Practicing In-	16,483	18,134	17,944	17,964	

State 19,921

Composite Action Index						Composite Action Index					
Total Actions/Total Licensed Physicians	6.96	16.61	11.75	12.13	9.87	Total Actions/Total Licensed Physicians	5.67	6.63	6.35	5.06	5.31
Total Actions/Practicing In-State Physicians	9.21	21.33	16.05	14.74	14.82	Total Actions/Practicing In-State Physicians	7.83	10.56	8.99	7.19	7.63
Total Prejudicial Actions/Total Licensed Physicians	6.52	15.44	11.28	11.39	8.10	Total Prejudicial Actions/Total Licensed Physicians	4.83	5.86	5.65	4.43	4.11
Total Prejudicial Actions/Practicing In-State Physicians	8.64	19.83	15.40	13.83	12.16	Total Prejudicial Actions/Practicing In-State Physicians	6.68	9.34	8.00	6.30	5.90
Composite Action Index	7.83	18.30	13.62	13.02	11.24	Composite Action Index	6.25	8.10	7.25	5.74	5.74

Summary of 2005 Board Actions

Guam Board of Medical Examiners

Health Professionals Licensing Office

651 Legacy Square Commercial Complex,
South Route 10, Suite 9
Margilao, GU 96913
(671) 735-7406; Fax: (671) 735-7413

Summary of 2005 Board Actions

Hawaii Board of Medical Examiners

Department of Commerce and Consumer Affairs

P.O. BOX 3469

Honolulu, HI 96813
http://www.hawaii.gov/dcca/pvl
(808) 586-3000; Fax: (808) 586-2874

Board Information

Board Size/Composition	7 / 6 MD, 1 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO

Board Actions	2005	2004	2003	2002	2001
Total Actions	NR*	4	NR	NR	NR
Loss of License or Licensed Privilege	NR	2	NR	NR	NR
Restriction of License or Licensed Privilege	NR	2	NR	NR	NR
Other Prejudicial Actions	NR	0	NR	NR	NR
Total Prejudicial Actions	NR	4	NR	NR	NR
Non-Prejudicial Actions	NR	0	NR	NR	NR
Number of Physicians with Prejudicial Actions	NR	2	NR	NR	NR
Number of Physicians with Non-Prejudicial Actions	NR	0	NR	NR	NR
Total Number of Physicians with Actions	NR	2	NR	NR	NR

Physician Population

Total Number of Licensed	NR	NR	325	301	232

Board Information

Board Size/Composition	11 / 7 MD, 2 DO, 2 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, POD

Board Actions	2005	2004	2003	2002	2001
Total Actions	19	16	13	8	8
Loss of License or Licensed Privilege	11	6	8	4	2
Restriction of License or Licensed Privilege	4	0	0	0	1
Other Prejudicial Actions	4	10	5	4	5
Total Prejudicial Actions	19	16	13	8	8
Non-Prejudicial Actions	0	0	0	0	0
Number of Physicians with Prejudicial Actions	19	16	13	8	8
Number of Physicians with Non-Prejudicial Actions	0	0	0	0	0
Total Number of Physicians with Actions	19	16	13	8	8

Physician Population

Physicians					
Total Number of Licensed Physicians Practicing In-State	NR	NR	201	183	148
Composite Action Index					
Total Actions/Total Licensed Physicians	NA**	NA	NA	NA	NA
Total Actions/Practicing In-State Physicians	NA	NA	NA	NA	NA
Total Prejudicial Actions/Total Licensed Physicians	NA	NA	NA	NA	NA
Total Prejudicial Actions/Practicing In-State Physicians	NA	NA	NA	NA	NA
Composite Action Index	NA	NA	NA	NA	NA

*Not Reported ** Not Applicable

Total Number of Licensed Physicians	7,908	6,948	6,944	6,315	6,486
Total Number of Licensed Physicians Practicing In-State	3,965	3,613	3,516	3,363	3,318
Composite Action Index					
Total Actions/Total Licensed Physicians	2.40	2.30	1.87	1.27	1.23
Total Actions/Practicing In-State Physicians	4.79	4.43	3.70	2.38	2.41
Total Prejudicial Actions/Total Licensed Physicians	2.40	2.30	1.87	1.27	1.23
Total Prejudicial Actions/Practicing In-State Physicians	4.79	4.43	3.70	2.38	2.41
Composite Action Index	3.60	3.37	2.78	1.82	1.82

Summary of 2005 Board Actions

Idaho State Board of Medicine

1755 Westgate Dr, Suite 140
Boise, ID 83704
http://www.bom.state.id.us
(208) 327-7000; Fax: (208) 327-7005

Board Information

Summary of 2005 Board Actions

Illinois Department of Financial and Professional Regulation

320 W. Washington St, 3rd Floor
Springfield, IL 62786
http://www.ildfpr.com
(312) 814-4500; Fax: (312) 814-1837

Board Information

Board Size/Composition	10 / 6 MD, 1 DO, 2 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, MR, DEI, AT, PT, PTA, OT, OTA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	21	10	14	16	19
Loss of License or Licensed Privilege	10	7	4	6	7
Restriction of License or Licensed Privilege	2	2	5	5	8
Other Prejudicial Actions	8	0	5	4	3
Total Prejudicial Actions	20	9	14	15	18
Non-Prejudicial Actions	1	1	0	1	1
Number of Physicians with Prejudicial Actions	18	9	13	12	14
Number of Physicians with Non-Prejudicial Actions	1	1	0	1	1
Total Number of Physicians with Actions	18	10	13	13	15

Physician Population					
Total Number of Licensed Physicians	4,121	3,834	3,743	3,651	3,670
Total Number of Licensed Physicians Practicing In-State	2,855	2,570	2,493	2,426	3,489

Composite Action Index

Board Size/Composition	16 / 10 MD, 2 DO, 2 public, 2 other
Board Meeting Frequency	Biweekly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, DO, PA, CHI

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	281	240	198	177	121
Loss of License or Licensed Privilege	173	125	53	75	45
Restriction of License or Licensed Privilege	38	52	50	46	19
Other Prejudicial Actions	35	42	63	36	33
Total Prejudicial Actions	246	219	166	157	97
Non-Prejudicial Actions	35	21	32	20	24
Number of Physicians with Prejudicial Actions	222	216	123	136	91
Number of Physicians with Non-Prejudicial Actions	35	24	31	21	24
Total Number of Physicians with Actions	239	225	142	154	110

Physician Population					
Total Number of Licensed Physicians	38,258	41,301	39,037	36,502	39,474
Total Number of Licensed Physicians Practicing In-State	32,713	34,082	32,842	31,422	32,449

Composite Action Index

Total Actions/Total Licensed Physicians	5.10	2.61	3.74	4.38	5.18	Total Actions/Total Licensed Physicians	7.34	5.81	5.07	4.85	3.07
Total Actions/Practicing In-State Physicians	7.36	3.89	5.62	6.60	5.45	Total Actions/Practicing In-State Physicians	8.59	7.04	6.03	5.63	3.73
Total Prejudicial Actions/Total Licensed Physicians	4.85	2.35	3.74	4.11	4.90	Total Prejudicial Actions/Total Licensed Physicians	6.43	5.30	4.25	4.30	2.46
Total Prejudicial Actions/Practicing In-State Physicians	7.01	3.50	5.62	6.18	5.16	Total Prejudicial Actions/Practicing In-State Physicians	7.52	6.43	5.05	5.00	2.99
Composite Action Index	6.08	3.09	4.68	5.32	5.17	Composite Action Index	7.47	6.15	5.10	4.94	3.06

Summary of 2005 Board Actions

Medical Licensing Board of Indiana

402 W. Washington Street, Room W072
Indianapolis, IN 46204
http://www.ai.org/hpb/
(317) 232-2960; Fax: (317) 233-4236

Board Information

Board Size/Composition	7 / 5 MD, 1 DO, 1 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, DO, ACU, PT, PA, RT

Summary of 2005 Board Actions

Iowa Board of Medical Examiners

400 SouthWest Eighth Street, Suite C
Des Moines, IA 50309-4686
http://www.docboard.org/ia/ia_home.htm
(515) 281-5171; Fax: (515) 242-5908

Board Information

Board Size/Composition	10 / 5 MD, 2 DO, 3 public
Board Meeting Frequency	Every eight weeks
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, ACU

Board Actions	2005	2004	2003	2002	2001	Board Actions	2005	2004	2003	2002	2001
Total Actions	66	62	72	56	45	Total Actions	54	65	37	54	57
Loss of License or Licensed Privilege	41	40	51	37	22	Loss of License or Licensed Privilege	13	24	16	21	23
Restriction of License or Licensed Privilege	14	10	11	8	12	Restriction of License or Licensed Privilege	17	21	12	12	21
Other Prejudicial Actions	4	1	9	6	3	Other Prejudicial Actions	16	11	5	17	12
Total Prejudicial Actions	59	51	71	51	37	Total Prejudicial Actions	46	56	33	50	56
Non-Prejudicial Actions	7	11	1	5	8	Non-Prejudicial Actions	8	9	4	4	1
Number of Physicians with Prejudicial Actions	53	35	52	32	29	Number of Physicians with Prejudicial Actions	44	46	30	44	52
Number of Physicians with Non-Prejudicial Actions	8	11	2	5	8	Number of Physicians with Non-Prejudicial Actions	8	10	4	5	1
Total Number of Physicians with Actions	59	46	52	37	37	Total Number of Physicians with Actions	52	55	34	48	53
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	24,260	24,943	22,096	26,708	24,945	Total Number of Licensed Physicians	9,876	9,833	9,791	9,776	9,854
Total Number of Licensed Physicians Practicing In-State	14,274	14,164	13,391	13,844	13,242	Total Number of Licensed Physicians Practicing In-State	6,058	5,990	5,952	5,885	5,856
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	2.72	2.49	3.26	2.10	1.80	Total Actions/Total Licensed Physicians	5.47	6.61	3.78	5.52	5.78
Total Actions/Practicing In-State Physicians	4.62	4.38	5.38	4.05	3.40	Total Actions/Practicing In-State Physicians	8.91	10.85	6.22	9.18	9.73
Total Prejudicial Actions/Total Licensed Physicians	2.43	2.04	3.21	1.91	1.48	Total Prejudicial Actions/Total Licensed Physicians	4.66	5.70	3.37	5.11	5.68
Total Prejudicial Actions/Practicing In-	4.13	3.60	5.30	3.68	2.79	Total Prejudicial Actions/Practicing In-State	7.59	9.35	5.54	8.50	9.56

State Physicians					
Composite Action Index	3.48	3.13	4.29	2.93	2.37

Physicians					
Composite Action Index	6.66	8.13	4.73	7.08	7.69

Summary of 2005 Board Actions

Kansas Board of Healing Arts

235 South Topeka Blvd
Topeka, KS 66603-3068
http://www.ksbha.org
(785) 296-7413; Fax: (785) 296-0852

Board Information

Board Size/Composition 15 / 5 MD, 3 DO, 3 public, 4 other

Board Meeting Frequency	Bimonthly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, DO, CHI, PT, PA, POD, RT, AT, NUT, OT

Board Actions	2005	2004	2003	2002	2001
Total Actions	38	40	27	30	40
Loss of License or Licensed Privilege	17	18	11	11	19
Restriction of License or Licensed Privilege	5	8	7	6	8

Summary of 2005 Board Actions

Kentucky Board of Medical Licensure

Hurstbourne Office Park
310 Whittington Pkwy, Suite 1B
Louisville, KY 40222
http://www.kbml.ky.gov
(502) 429-7150; Fax: (502) 429-7158

Board Information

Board Size/Composition	15 / 10 MD, 2 DO, 3 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, SA, AT

Board Actions	2005	2004	2003	2002	2001
Total Actions	96	126	143	98	86
Loss of License or Licensed Privilege	36	55	64	41	43

Other Prejudicial Actions	7	10	4	8	9
Total Prejudicial Actions	29	36	23	25	36
Non-Prejudicial Actions	9	4	4	5	4
Number of Physicians with Prejudicial Actions	24	37	20	25	33
Number of Physicians with Non-Prejudicial Actions	9	5	5	7	4
Total Number of Physicians with Actions	32	38	25	28	37
Physician Population					
Total Number of Licensed Physicians	10,123	9,773	9,529	9,417	9,366
Total Number of Licensed Physicians Practicing In-State	6,917	6,967	6,705	6,582	6,575
Composite Action Index					
Total Actions/Total Licensed Physicians	3.75	4.09	2.83	3.19	4.27
Total Actions/Practicing In-State Physicians	5.49	5.74	4.03	4.56	6.08
Total Prejudicial Actions/Total Licensed Physicians	2.86	3.68	2.41	2.65	3.84
Total Prejudicial Actions/Practicing In-State Physicians	4.19	5.17	3.43	3.80	5.48
Composite Action Index	4.08	4.67	3.18	3.55	4.92

Restriction of License or Licensed Privilege	36	40	54	38	31
Other Prejudicial Actions	10	16	16	13	8
Total Prejudicial Actions	82	111	134	92	82
Non-Prejudicial Actions	14	15	9	6	4
Number of Physicians with Prejudicial Actions	67	93	103	72	62
Number of Physicians with Non-Prejudicial Actions	16	16	15	8	9
Total Number of Physicians with Actions	75	99	104	77	65
Physician Population					
Total Number of Licensed Physicians	13,623	13,337	13,083	13,034	12,834
Total Number of Licensed Physicians Practicing In-State	9,377	9,327	9,076	9,022	8,634
Composite Action Index					
Total Actions/Total Licensed Physicians	7.05	9.45	10.93	7.52	6.70
Total Actions/Practicing In-State Physicians	10.24	13.51	15.76	10.86	9.96
Total Prejudicial Actions/Total Licensed Physicians	6.02	8.32	10.24	7.06	6.39
Total Prejudicial Actions/Practicing In-State Physicians	8.74	11.90	14.76	10.20	9.50

Composite Action Index	8.01	10.80	12.92	8.91	8.14

Summary of 2005 Board Actions

Louisiana State Board of Medical Examiners

P.O. BOX 30250
New Orleans, LA 70190-0250
http://www.lsbme.louisiana.gov
(504) 568-6820; Fax: (504) 568-8893

Board Information

Board Size/Composition	7 / 7 MD
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, ACU, OP, PA, POD, RT

Board Actions	2005	2004	2003	2002	2001
Total Actions	64	82	82	71	57
Loss of License or Licensed Privilege	23	34	29	26	17
Restriction of License or Licensed Privilege	31	33	40	24	25
Other Prejudicial Actions	3	3	5	10	5
Total Prejudicial Actions	57	70	74	60	47

Summary of 2005 Board Actions

Maine Board of Licensure in Medicine

137 State House Station
August, ME 04333-0137
http://www.docboard.org/me/me_home.htm
(207) 287-3601; Fax: (207) 287-6590

Board Information

Board Size/Composition	9 / 6 MD, 3 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, PA

Board Actions	2005	2004	2003	2002	2001
Total Actions	15	16	27	18	13
Loss of License or Licensed Privilege	5	8	7	11	6
Restriction of License or Licensed Privilege	2	1	1	2	1
Other Prejudicial Actions	5	4	10	4	5
Total Prejudicial Actions	12	13	18	17	12

Non-Prejudicial Actions	7	12	8	11	10	Non-Prejudicial Actions	3	3	9	1	1
Number of Physicians with Prejudicial Actions	48	54	58	48	37	Number of Physicians with Prejudicial Actions	11	12	17	13	12
Number of Physicians with Non-Prejudicial Actions	10	16	9	12	13	Number of Physicians with Non-Prejudicial Actions	3	3	9	1	1
Total Number of Physicians with Actions	55	65	66	57	45	Total Number of Physicians with Actions	14	14	25	14	13
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	15,886	16,391	16,348	16,177	16,576	Total Number of Licensed Physicians	5,539	5,098	4,968	4,922	4,885
Total Number of Licensed Physicians Practicing In-State 11,221		10,963	11,057	10,718	10,968	Total Number of Licensed Physicians Practicing In-State	3,116	3,219	3,236	3,128	2,964
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	4.03	5.00	5.02	4.39	3.44	Total Actions/Total Licensed Physicians	2.71	3.14	5.43	3.66	2.66
Total Actions/Practicing In-State Physicians	5.70	7.48	7.42	6.62	5.20	Total Actions/Practicing In-State Physicians	4.81	4.97	8.34	5.75	4.39
Total Prejudicial Actions/Total Licensed Physicians	3.59	4.27	4.53	3.71	2.84	Total Prejudicial Actions/Total Licensed Physicians	2.17	2.55	3.62	3.45	2.46
Total Prejudicial Actions/Practicing In-State Physicians	5.08	6.39	6.69	5.60	4.29	Total Prejudicial Actions/Practicing In-State Physicians	3.85	4.04	5.56	5.43	4.05
Composite Action Index	4.60	5.78	5.91	5.08	3.94	Composite Action Index	3.38	3.67	5.74	4.58	3.39

Summary of 2005 Board Actions
Maine Board of Osteopathic Licensure
142 State House Station
Augusta, ME 04333-0142

Summary of 2005 Board Actions
Maryland Board of Physicians
P.O. BOX 2571
Baltimore, MD 21215-0095

http://www.docboard.org/me-osteo
(207) 287-2480; Fax: (207) 287-3015

Board Information	
Board Size/Composition	9 / 6 DO, 3 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO, PA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	NR*	8	7	9	5
Loss of License or Licensed Privilege	NR	3	1	1	1
Restriction of License or Licensed Privilege	NR	2	1	3	3
Other Prejudicial Actions	NR	2	4	3	1
Total Prejudicial Actions	NR	7	6	7	5
Non-Prejudicial Actions	NR	1	1	2	0
Number of Physicians with Prejudicial Actions	NR	5	5	6	5
Number of Physicians with Non-Prejudicial Actions	NR	1	1	2	0
Total Number of Physicians with Actions	NR	6	5	7	5

Physician Population					
Total Number of Licensed Physicians	680	696	683	741	780

http://www.mbp.state.md.us
(410) 764-4777; Fax: (410) 358-2252

Board Information	
Board Size/Composition	21 / 13 MD, 6 public, 1 DO, 1 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, DO, ACU, PA, RT

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	81	71	74	70	66
Loss of License or Licensed Privilege	38	29	23	23	27
Restriction of License or Licensed Privilege	22	24	23	16	12
Other Prejudicial Actions	8	6	15	17	10
Total Prejudicial Actions	68	59	61	56	49
Non-Prejudicial Actions	13	12	13	14	17
Number of Physicians with Prejudicial Actions	61	56	59	52	45
Number of Physicians with Non-Prejudicial Actions	15	14	14	14	18
Total Number of Physicians with Actions	74	66	70	65	59

Physician Population					
Total Number of Licensed Physicians	23,910	23,440	23,101	22,561	22,068

Total Number of Licensed Physicians Practicing In-State	527	494	519	647	402	Total Number of Licensed Physicians Practicing In-State	17,207	15,321	16,919	14,256
						16,376				
Composite Action Index						**Composite Action Index**				
Total Actions/Total Licensed Physicians	NA**	11.49	10.25	12.15	6.41	Total Actions/Total Licensed Physicians	3.39	3.03	3.20	3.10	2.99
Total Actions/Practicing In-State Physicians	NA	16.19	13.49	13.91	12.44	Total Actions/Practicing In-State Physicians	4.95	4.13	4.83	4.14	4.63
Total Prejudicial Actions/Total Licensed Physicians	NA	10.06	8.78	9.45	6.41	Total Prejudicial Actions/Total Licensed Physicians	2.84	2.52	2.64	2.48	2.22
Total Prejudicial Actions/Practicing In-State Physicians	NA	14.17	11.56	10.82	12.44	Total Prejudicial Actions/Practicing In-State Physicians	4.15	3.43	3.98	3.31	3.44
Composite Action Index	NA	12.98	11.02	11.58	9.42	Composite Action Index	3.83	3.28	3.66	3.26	3.32

*Not Reported **Not Applicable

Summary of 2005 Board Actions

Massachusetts Board of Registration in Medicine

560 Harrison Ave, Suite G-4
Boston, MA 02118
http://www.massmedboard.org
(617) 654-9800; Fax: (617) 451-9568

Board Information

Board Size/Composition	7 / 5 MD, 2 public
Board Meeting Frequency	Monthly

Summary of 2005 Board Actions

Michigan Board of Medicine

P.O. BOX 30670
Lansing, MI 48909-8170
http://www.michigan.gov/healthlicense
(517) 335-0918; Fax: (517) 373-2179

Board Information

Board Size/Composition	19 / 10 MD, 8 public, 1 other
Board Meeting Frequency	Bimonthly

Standard of Proof Required	Preponderance of the Evidence				
Professions Regulated by Board	MD, DO, ACU				
Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	121	138	117	134	111
Loss of License or Licensed Privilege	63	66	58	57	50
Restriction of License or Licensed Privilege	31	40	40	50	37
Other Prejudicial Actions	19	26	10	20	20
Total Prejudicial Actions	113	132	108	127	107
Non-Prejudicial Actions	8	6	9	7	4
Number of Physicians with Prejudicial Actions	92	108	87	93	76
Number of Physicians with Non-Prejudicial Actions	9	6	10	8	6
Total Number of Physicians with Actions	98	111	92	100	79
Physician Population					
Total Number of Licensed Physicians	33,392	33,178	31,346	32,328	29,168
Total Number of Licensed Physicians Practicing In-State	28,596	27,251	26,172	26,697	20,628
Composite Action Index					
Total Actions/Total Licensed Physicians	3.62	4.16	3.73	4.15	3.81
Total Actions/Practicing In-State Physicians	4.23	5.06	4.47	5.02	5.38
Total Prejudicial	3.38	3.98	3.45	3.93	3.67

Standard of Proof Required	Preponderance of the Evidence				
Professions Regulated by Board	MD				
Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	110	127	100	107	121
Loss of License or Licensed Privilege	42	47	32	38	38
Restriction of License or Licensed Privilege	23	33	21	26	29
Other Prejudicial Actions	26	21	32	13	21
Total Prejudicial Actions	91	101	85	77	88
Non-Prejudicial Actions	19	26	15	30	33
Number of Physicians with Prejudicial Actions	82	91	78	66	77
Number of Physicians with Non-Prejudicial Actions	19	27	18	30	33
Total Number of Physicians with Actions	93	102	90	90	100
Physician Population					
Total Number of Licensed Physicians	30,575	33,528	33,018	35,470	32,615
Total Number of Licensed Physicians Practicing In-State	22,066	21,719	24,642	25,650	23,861
Composite Action Index					
Total Actions/Total Licensed Physicians	3.60	3.79	3.03	3.02	3.71
Total Actions/Practicing In-State Physicians	4.99	5.85	4.06	4.17	5.07
Total Prejudicial	2.98	3.01	2.57	2.17	2.70

Actions/Total Licensed Physicians					
Total Prejudicial Actions/Practicing In-State Physicians	3.95	4.84	4.13	4.76	5.19
Composite Action Index	3.80	4.51	3.94	4.46	4.51

Actions/Total Licensed Physicians					
Total Prejudicial Actions/Practicing In-State Physicians	4.12	4.65	3.45	3.00	3.69
Composite Action Index	3.92	4.32	3.28	3.09	3.79

Summary of 2005 Board Actions

Michigan Board of Osteopathic Medicine and Surgery

P.O. BOX 30670
Lansing, MI 48909-8170
http://www.michigan.gov/healthlicense
(517) 335-0918; Fax: (517) 373-2179

Board Information

Board Size/Composition	9 / 5 DO, 3 public, 1 other
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO

Board Actions	2005	2004	2003	2002	2001

Summary of 2005 Board Actions

Minnesota Board of Medical Practice

University Park Plaza
2829 University Ave SE, Suite 500
Minneapolis, MN 55414-3246
http://www.bmp.state.mn.us/
(612) 617-2130; Fax: (612) 617-2166

Board Information

Board Size/Composition	16 / 10 MD, 1 DO, 5 public
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, AT, ACU, RT, NM

Board Actions	2005	2004	2003	2002	2001

Total Actions	47	47	34	43	52
Loss of License or Licensed Privilege	16	21	9	12	16
Restriction of License or Licensed Privilege	16	10	7	12	16
Other Prejudicial Actions	11	8	8	5	7
Total Prejudicial Actions	43	39	24	29	39
Non-Prejudicial Actions	4	8	10	14	13
Number of Physicians with Prejudicial Actions	36	34	23	26	35
Number of Physicians with Non-Prejudicial Actions	4	8	10	15	13
Total Number of Physicians with Actions	37	38	32	38	45
Physician Population					
Total Number of Licensed Physicians	6,376	6,936	6,592	6,683	6,622
Total Number of Licensed Physicians Practicing In-State	5,205	4,911	5,178	5,307	5,228
Composite Action Index					
Total Actions/Total Licensed Physicians	7.37	6.78	5.16	6.43	7.85
Total Actions/Practicing In-State Physicians	9.03	9.57	6.57	8.10	9.95
Total Prejudicial Actions/Total Licensed Physicians	6.74	5.62	3.64	4.34	5.89
Total Prejudicial Actions/Practicing In-State	8.26	7.94	4.63	5.46	7.46

Total Actions	67	61	57	70	55
Loss of License or Licensed Privilege	10	7	10	14	13
Restriction of License or Licensed Privilege	19	17	15	17	12
Other Prejudicial Actions	16	21	20	17	19
Total Prejudicial Actions	45	45	45	48	44
Non-Prejudicial Actions	22	16	12	22	11
Number of Physicians with Prejudicial Actions	42	44	42	42	40
Number of Physicians with Non-Prejudicial Actions	25	16	12	24	12
Total Number of Physicians with Actions	63	56	49	62	49
Physician Population					
Total Number of Licensed Physicians	17,609	17,392	17,174	16,787	16,418
Total Number of Licensed Physicians Practicing In-State	13,678	13,371	13,165	12,824	12,507
Composite Action Index					
Total Actions/Total Licensed Physicians	3.80	3.51	3.32	4.17	3.35
Total Actions/Practicing In-State Physicians	4.90	4.56	4.33	5.46	4.40
Total Prejudicial Actions/Total Licensed	2.56	2.59	2.62	2.86	2.68

Physicians					
Composite Action Index	7.85	7.48	5.00	6.09	7.79

Physicians					
Total Prejudicial Actions/Practicing In-State Physicians	3.29	3.37	3.42	3.74	3.52
Composite Action Index	3.64	3.51	3.42	4.06	3.49

Summary of 2005 Board Actions

Mississippi State Board of Medical Licensure

1867 Crane Ridge Drive, Suite 200B
Jackson, MS 39216
http://www.msbml.state.ms.us
(601) 987-3079; Fax: (601) 987-4159

Board Information

Board Size/Composition	9 / 8 MD, 1 DO
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, POD

Board Actions	2005	2004	2003	2002	2001
Total Actions	20	15	18	38	44
Loss of License or Licensed Privilege	9	6	6	12	12
Restriction of License or	2	2	4	10	14

Summary of 2005 Board Actions

Missouri State Board of Healing Arts

3605 Missouri Blvd
Jefferson City, MO 65109
http://www.pr.mo.gov/healingarts.asp
(573) 751-0098; Fax: (573) 751-3166

Board Information

Board Size/Composition	9 / 5 MD, 3 DO, 1 public
Board Meeting Frequency	Every six weeks
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, PT, PTA, SLP, SLA, AUD, AA, PER, AT, ANA

Board Actions	2005	2004	2003	2002	2001
Total Actions	97	217	80	61	73
Loss of License or Licensed Privilege	32	128	27	16	19
Restriction of License or	16	34	26	24	28

Licensed Privilege						Licensed Privilege					
Other Prejudicial Actions	3	2	1	2	2	Other Prejudicial Actions	16	11	15	14	14
Total Prejudicial Actions	14	10	11	24	28	Total Prejudicial Actions	64	173	68	54	61
Non-Prejudicial Actions	6	5	7	14	16	Non-Prejudicial Actions	33	44	12	7	12
Number of Physicians with Prejudicial Actions	12	10	9	16	23	Number of Physicians with Prejudicial Actions	57	164	61	50	55
Number of Physicians with Non-Prejudicial Actions	6	5	7	14	19	Number of Physicians with Non-Prejudicial Actions	34	45	13	7	13
Total Number of Physicians with Actions	17	14	16	30	38	Total Number of Physicians with Actions	83	182	71	56	67
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	8,476	8,412	8,295	8,208	8,415	Total Number of Licensed Physicians	21,908	21,249	20,248	19,966	20,994
Total Number of Licensed Physicians Practicing In-State	5,383	5,074	4,946	4,862	5,756	Total Number of Licensed Physicians Practicing In-State	14,402	14,346	14,403	13,080	13,625
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	2.36	1.78	2.17	4.63	5.23	Total Actions/Total Licensed Physicians	4.43	10.21	3.95	3.06	3.48
Total Actions/Practicing In-State Physicians	3.72	2.96	3.64	7.82	7.64	Total Actions/Practicing In-State Physicians	6.74	15.13	5.55	4.66	5.36
Total Prejudicial Actions/Total Licensed Physicians	1.65	1.19	1.33	2.92	3.33	Total Prejudicial Actions/Total Licensed Physicians	2.92	8.14	3.36	2.70	2.91
Total Prejudicial Actions/Practicing In-State Physicians	2.60	1.97	2.22	4.94	4.86	Total Prejudicial Actions/Practicing In-State Physicians	4.44	12.06	4.72	4.13	4.48
Composite Action Index	2.58	1.97	2.34	5.08	5.27	Composite Action Index	4.63	11.38	4.40	3.64	4.05

Summary of 2005 Board Actions

Montana Board of Medical Examiners

P.O. BOX 200513
Helena, MT 59620-0513
http://www.mt.gov
(406) 841-2300; Fax: (406) 841-2363

Board Information

Board Size/Composition	11 / 5 MD, 1 DO, 2 public, 3 other
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, ACU, POD, NUT, EMT,

Board Actions	2005	2004	2003	2002	2001
Total Actions	11	15	23	19	8
Loss of License or Licensed Privilege	8	12	13	11	3
Restriction of License or Licensed Privilege	0	2	4	4	4
Other Prejudicial Actions	1	0	4	1	1
Total Prejudicial Actions	9	14	21	16	8
Non-Prejudicial Actions	2	1	2	3	0
Number of Physicians with Prejudicial Actions	9	13	19	13	8
Number of Physicians with Non-Prejudicial Actions	2	1	2	3	0
Total Number of Physicians with Actions	11	14	19	14	8

Summary of 2005 Board Actions

Nebraska Board of Medicine and Surgery

P.O. BOX 94986
Lincoln, NE 68509-4986
http://www.hhs.state.ne.us
(402) 471-2118; Fax: (402) 471-3577

Board Information

Board Size/Composition	8 / 5 MD, 1 DO, 2 public
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, DO, PA, ACU

Board Actions	2005	2004	2003	2002	2001
Total Actions	58	37	41	30	19
Loss of License or Licensed Privilege	18	10	10	9	7
Restriction of License or Licensed Privilege	13	6	7	5	3
Other Prejudicial Actions	21	18	21	15	7
Total Prejudicial Actions	52	34	38	29	17
Non-Prejudicial Actions	6	3	3	1	2
Number of Physicians with Prejudicial Actions	47	33	37	25	17
Number of Physicians with Non-Prejudicial Actions	6	3	3	1	2
Total Number of Physicians with Actions	51	35	40	26	18

Physician Population					
Total Number of Licensed Physicians	3,982	3,781	3,732	3,730	2,986
Total Number of Licensed Physicians Practicing In-State	2,246	2,178	2,180	3,106	2,067
Composite Action Index					
Total Actions/Total Licensed Physicians	2.76	3.97	6.16	5.09	2.68
Total Actions/Practicing In-State Physicians	4.90	6.89	10.55	6.12	3.87
Total Prejudicial Actions/Total Licensed Physicians	2.26	3.70	5.63	4.29	2.68
Total Prejudicial Actions/Practicing In-State Physicians	4.01	6.43	9.63	5.15	3.87
Composite Action Index	3.48	5.25	7.99	5.16	3.27

Physician Population					
Total Number of Licensed Physicians	6,569	6,128	6,339	5,912	6,073
Total Number of Licensed Physicians Practicing In-State	3,894	3,745	3,758	3,697	3,664
Composite Action Index					
Total Actions/Total Licensed Physicians	8.83	6.04	6.47	5.07	3.13
Total Actions/Practicing In-State Physicians	14.89	9.88	10.91	8.11	5.19
Total Prejudicial Actions/Total Licensed Physicians	7.92	5.55	5.99	4.91	2.80
Total Prejudicial Actions/Practicing In-State Physicians	13.35	9.08	10.11	7.84	4.64
Composite Action Index	11.25	7.64	8.37	6.48	3.94

Summary of 2005 Board Actions

Nevada State Board of Medical Examiners

1105 Terminal Way, Suite 301
Reno, NV 89510
http://www.medboard.nv.gov
(775) 688-2559; Fax: (775) 688-2321

Board Information	
Board Size/Composition	9 / 6 MD, 3 other
Board Meeting Frequency	Quarterly

Summary of 2005 Board Actions

Nevada State Board of Osteopathic Medicine

860 E. Flamingo Rd, Suite G
Las Vegas, NV 89121
http://www.osteo.state.nv.us
(702) 732-2147; Fax: (702) 732-2079

Board Information	
Board Size/Composition	7 / 5 DO, 2 public
Board Meeting Frequency	Quarterly

Standard of Proof Required	Preponderance of the Evidence					Standard of Proof Required	Clear and Convincing				
Professions Regulated by Board	MD, PA , RT					Professions Regulated by Board	DO, PA				
Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**	**Board Actions**	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	18	8	17	20	21	Total Actions	3	4	2	1	2
Loss of License or Licensed Privilege	11	6	11	8	11	Loss of License or Licensed Privilege	3	3	2	0	2
Restriction of License or Licensed Privilege	0	0	0	1	5	Restriction of License or Licensed Privilege	0	1	0	1	0
Other Prejudicial Actions	7	1	6	7	2	Other Prejudicial Actions	0	0	0	0	0
Total Prejudicial Actions	18	7	17	16	18	Total Prejudicial Actions	3	4	2	1	2
Non-Prejudicial Actions	0	1	0	4	3	Non-Prejudicial Actions	0	0	0	0	0
Number of Physicians with Prejudicial Actions	17	7	16	15	17	Number of Physicians with Prejudicial Actions	3	3	2	1	2
Number of Physicians with Non-Prejudicial Actions	0	1	0	3	3	Number of Physicians with Non-Prejudicial Actions	0	0	0	0	0
Total Number of Physicians with Actions	17	7	16	16	19	Total Number of Physicians with Actions	3	3	2	1	2
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	5,935	5,986	4,554	4,737	4,344	Total Number of Licensed Physicians	739	773	703	622	571
Total Number of Licensed Physicians Practicing In-State	4,026	5,120	3,605	3,700	3,515	Total Number of Licensed Physicians Practicing In-State	419	463	421	342	322
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	3.03	1.34	3.73	4.22	4.83	Total Actions/Total Licensed Physicians	4.06	5.17	2.84	1.61	3.50
Total Actions/Practicing In-State Physicians	4.47	1.56	4.72	5.41	5.97	Total Actions/Practicing In-State Physicians	7.16	8.64	4.75	2.92	6.21
Total Prejudicial Actions/Total Licensed Physicians	3.03	1.17	3.73	3.38	4.14	Total Prejudicial Actions/Total Licensed Physicians	4.06	5.17	2.84	1.61	3.50

Total Prejudicial Actions/Practicing In-State Physicians	4.47	1.37	4.72	4.32	5.12
Composite Action Index	3.75	1.36	4.22	4.33	5.02

Total Prejudicial Actions/Practicing In-State Physicians	7.16	8.64	4.75	2.92	6.21
Composite Action Index	5.61	6.91	3.80	2.27	4.86

Summary of 2005 Board Actions

New Hampshire Board of Medicine

2 Industrial Park Drive, Suite 8
Concord, NH 03301-8520
http://www.state.nh.us/medicine
(603) 271-1203; Fax: (603) 271-6702

Board Information

Board Size/Composition	9 / 5 MD, 2 public, 2 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA

Board Actions	2005	2004	2003	2002	2001
Total Actions	26	25	18	24	28
Loss of License or Licensed Privilege	12	11	11	6	10
Restriction of License or Licensed Privilege	5	5	1	5	3
Other Prejudicial Actions	7	8	3	11	13

Summary of 2005 Board Actions

New Jersey State Board of Medical Examiners

P.O. BOX 183
Trenton, NJ 08625-0183
http://www.state.nj.us./lps/ca/medical.htm#bme5
(609) 826-7100; Fax: (609) 826-7117

Board Information

Board Size/Composition	21 / 9 MD, 2 DO, 4 public, 6 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, DEH, NM, PA, ACU, PER, ELE, HAD, BLD

Board Actions	2005	2004	2003	2002	2001
Total Actions	98	135	138	155	140
Loss of License or Licensed Privilege	37	75	63	86	75
Restriction of License or Licensed Privilege	27	27	22	29	32
Other Prejudicial Actions	16	18	36	28	16

Total Prejudicial Actions	24	24	15	22	26
Non-Prejudicial Actions	2	1	3	2	2
Number of Physicians with Prejudicial Actions	23	22	12	23	22
Number of Physicians with Non-Prejudicial Actions	2	1	3	2	2
Total Number of Physicians with Actions	24	22	15	23	24
Physician Population					
Total Number of Licensed Physicians	4,981	4,819	4,551	4,395	4,241
Total Number of Licensed Physicians Practicing In-State	3,429	3,332	3,226	3,124	3,042
Composite Action Index					
Total Actions/Total Licensed Physicians	5.22	5.19	3.96	5.46	6.60
Total Actions/Practicing In-State Physicians	7.58	7.50	5.58	7.68	9.20
Total Prejudicial Actions/Total Licensed Physicians	4.82	4.98	3.30	5.01	6.13
Total Prejudicial Actions/Practicing In-State Physicians	7.00	7.20	4.65	7.04	8.55
Composite Action Index	6.15	6.22	4.37	6.30	7.62

Total Prejudicial Actions	80	120	122	143	123
Non-Prejudicial Actions	18	15	16	12	17
Number of Physicians with Prejudicial Actions	70	96	108	128	118
Number of Physicians with Non-Prejudicial Actions	18	16	17	14	19
Total Number of Physicians with Actions	87	111	123	140	128
Physician Population					
Total Number of Licensed Physicians	32,524	33,032	31,392	55,275	32,600
Total Number of Licensed Physicians Practicing In-State	25,526	NR*	NR	32,604	30,721
Composite Action Index					
Total Actions/Total Licensed Physicians	3.01	4.09	4.40	2.80	4.29
Total Actions/Practicing In-State Physicians	3.84	NA**	NA	4.75	4.56
Total Prejudicial Actions/Total Licensed Physicians	2.46	2.59	3.77	3.63	3.89
Total Prejudicial Actions/Practicing In-State Physicians	3.13	NA	NA	4.39	4.00
Composite Action Index	3.11	NA	NA	3.63	4.16

*Not Reported **Not Applicable

Summary of 2005 Board Actions

New Mexico Medical Board

2055 S. Pacheco, Building 400
Santa Fe, NM 87505
http://www.nmmb.state.nm.us
(505) 476-7220; Fax: (505) 476-7237

Board Information

Board Size/Composition	9 / 6 MD, 2 public, 1 other
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, PA, ANA

Board Actions	2005	2004	2003	2002	2001
Total Actions	34	40	27	34	24
Loss of License or Licensed Privilege	7	13	10	12	5
Restriction of License or Licensed Privilege	7	8	3	11	7
Other Prejudicial Actions	12	11	5	7	9
Total Prejudicial Actions	26	32	18	30	21
Non-Prejudicial Actions	8	8	9	4	3
Number of Physicians with Prejudicial Actions	26	27	18	27	21
Number of Physicians with Non-Prejudicial Actions	8	8	10	4	3
Total Number of Physicians with Actions	33	35	25	31	24

New Mexico Board of Osteopathic Medical Examiners

2550 Cerrillos Road
Santa Fe, NM 87501-5101
http://www.rld.state.nm.us/b&c/Osteo
(505) 476-4695; Fax: (505) 476-7237

Board Information

Board Size/Composition	5 / 3 DO, 2 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO

Board Actions	2005	2004	2003	2002	2001
Total Actions	0	0	0	0	0
Loss of License or Licensed Privilege	0	0	0	0	0
Restriction of License or Licensed Privilege	0	0	0	0	0
Other Prejudicial Actions	0	0	0	0	0
Total Prejudicial Actions	0	0	0	0	0
Non-Prejudicial Actions	0	0	0	0	0
Number of Physicians with Prejudicial Actions	0	0	0	0	0
Number of Physicians with Non-Prejudicial Actions	0	0	0	0	0
Total Number of Physicians with Actions	0	0	0	0	0

Physician Population					
Total Number of Licensed Physicians	7,412	6,548	6,200	5,805	5,722
Total Number of Licensed Physicians Practicing In-State	4,420	4,038	3,949	3,795	3,704
Composite Action Index					
Total Actions/Total Licensed Physicians	4.59	6.11	4.35	5.86	4.19
Total Actions/Practicing In-State Physicians	7.69	9.91	6.84	8.96	6.48
Total Prejudicial Actions/Total Licensed Physicians	3.51	4.89	2.90	5.17	3.67
Total Prejudicial Actions/Practicing In-State Physicians	5.88	7.92	4.56	7.91	5.67
Composite Action Index	5.42	7.21	4.66	6.97	5.00

Physician Population					
Total Number of Licensed Physicians	NR*	397	387	368	364
Total Number of Licensed Physicians Practicing In-State	NR	190	183	176	176
Composite Action Index					
Total Actions/Total Licensed Physicians	NA**	0.00	0.00	0.00	0.00
Total Actions/Practicing In-State Physicians	NA	0.00	0.00	0.00	0.00
Total Prejudicial Actions/Total Licensed Physicians	NA	0.00	0.00	0.00	0.00
Total Prejudicial Actions/Practicing In-State Physicians	NA	0.00	0.00	0.00	0.00
Composite Action Index	NA	0.00	0.00	0.00	0.00

*Not Reported **Not Applicable

New York State Board for Medicine (Licensure)

89 Washington Ave, 2nd Floor, West Wing

Albany, NY 12234

http://www.op.nysed.gov

(518) 474-3817; Fax: (518) 486-4846

Board Information

New York State Board for Professional Medical Conduct (Discipline)

Department of Health

433 River St, Suite 303

Troy, NY 12180-2299

http://www.health.state.ny.us/nysdoh/opmc/main.htm

(518) 402-0855; Fax: (518) 402-0866

Board Information

Board Size/Composition	25 / 18 MD, 2 public, 2 other
Board Meeting Frequency	3 per year
Standard of Proof Required	N/A
Professions Regulated by Board	MD, DO, PA, AT, MP, SA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions					
Loss of License or Licensed Privilege					
Restriction of License or Licensed Privilege					
Other Prejudicial Actions					
Total Prejudicial Actions					
Non-Prejudicial Actions					
Number of Physicians with Prejudicial Actions					
Number of Physicians with Non-Prejudicial Actions					
Total Number of Physicians with Actions					

Physician Population

Total Number of Licensed Physicians	78,306	76,843	75,067	74,063	72,920

Board Size/Composition	168 / 107 MD, 7 public, 54 other
Board Meeting Frequency	3 per year
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	534	534	508	461	503
Loss of License or Licensed Privilege	208	224	231	227	255
Restriction of License or Licensed Privilege	154	149	140	98	94
Other Prejudicial Actions	73	64	92	73	73
Total Prejudicial Actions	435	437	463	398	422
Non-Prejudicial Actions	99	97	45	63	81
Number of Physicians with Prejudicial Actions	388	383	395	342	369
Number of Physicians with Non-Prejudicial Actions	104	98	48	64	81
Total Number of Physicians with Actions	469	466	436	394	429

Physician Population

Total Number of Licensed Physicians Practicing In-State	59,581	59,581	56,995	56,995	63,427

Composite Action Index

Total Actions/Total Licensed Physicians	
Total Actions/Practicing In-State Physicians	
Total Prejudicial Actions/Total Licensed Physicians	
Total Prejudicial Actions/Practicing In-State Physicians	
Composite Action Index	

Total Number of Licensed Physicians	78,306	76,843	75,067	74,063	72,920
Total Number of Licensed Physicians Practicing In-State	59,581	59,581	56,995	56,995	63,427

Composite Action Index

Total Actions/Total Licensed Physicians	6.82	6.95	6.77	6.22	6.90
Total Actions/Practicing In-State Physicians	8.42	8.96	8.53	8.09	8.83
Total Prejudicial Actions/Total Licensed Physicians	5.56	5.69	6.17	5.37	5.79
Total Prejudicial Actions/Practicing In-State Physicians	6.86	7.33	7.77	6.98	7.40
Composite Action Index	6.91	7.23	7.31	6.67	7.23

Summary of 2005 Board Actions

North Carolina Medical Board

P.O. BOX 20007
Raleigh, NC 27619
http://www.ncmedboard.org
(919) 326-1100; Fax: (919) 326-1130

Board Information

North Dakota State Board of Medical Examiners

City Center Plaza
418 E. Broadway, Suite 12
Bismarck, ND 58501-4086
http://www.ndbomex.com/
(701) 328-6500; Fax: (701) 328-6505

Board Information

Board Size/Composition	12 / 8 MD, 3 public, 1 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, NP

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	210	192	135	126	169
Loss of License or Licensed Privilege	71	88	40	39	47
Restriction of License or Licensed Privilege	34	9	6	5	9
Other Prejudicial Actions	76	71	67	48	69
Total Prejudicial Actions	181	168	113	92	125
Non-Prejudicial Actions	29	24	22	34	44
Number of Physicians with Prejudicial Actions	152	142	94	71	90
Number of Physicians with Non-Prejudicial Actions	25	21	19	25	31
Total Number of Physicians with Actions	171	157	105	87	111

Physician Population					
Total Number of Licensed Physicians	28,452	29,410	27,307	29,308	28,325
Total Number of Licensed Physicians Practicing In-State	20,210	21,578	19,281	21,278	20,482

Composite Action Index

Board Size/Composition	11/ 8 MD, 1 DO, 2 public
Board Meeting Frequency	3 per year
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	11	12	31	25	14
Loss of License or Licensed Privilege	6	4	10	9	6
Restriction of License or Licensed Privilege	1	3	7	5	4
Other Prejudicial Actions	0	3	10	1	1
Total Prejudicial Actions	7	10	27	15	11
Non-Prejudicial Actions	4	2	4	10	3
Number of Physicians with Prejudicial Actions	7	9	21	13	11
Number of Physicians with Non-Prejudicial Actions	5	2	4	10	3
Total Number of Physicians with Actions	11	11	24	21	14

Physician Population					
Total Number of Licensed Physicians	2,836	2,679	2,694	2,702	2,556
Total Number of Licensed Physicians Practicing In-State	1,486	1,402	1,401	1,593	1,366

Composite Action Index

Total Actions/Total Licensed Physicians	7.38	6.53	4.94	4.30	5.97	Total Actions/Total Licensed Physicians	3.88	4.48	11.51	9.25	5.48
Total Actions/Practicing In-State Physicians	10.39	8.90	7.00	5.92	8.25	Total Actions/Practicing In-State Physicians	7.40	8.56	22.13	15.69	10.25
Total Prejudicial Actions/Total Licensed Physicians	6.36	5.71	4.14	3.14	4.41	Total Prejudicial Actions/Total Licensed Physicians	2.47	3.73	10.02	5.55	4.30
Total Prejudicial Actions/Practicing In-State Physicians	8.96	7.79	5.86	4.32	6.10	Total Prejudicial Actions/Practicing In-State Physicians	4.71	7.13	19.27	9.42	8.05
Composite Action Index	8.27	7.23	5.49	4.42	6.18	Composite Action Index	4.62	5.98	15.73	9.98	7.02

Summary of 2005 Board Actions

Commonwealth of the Northern Mariana Islands

Medical Professional Licensing Board

P.O. BOX 501458, CK
Saipan, MP 96950
http://www.cnmiguide.com
(670) 664-4811; Fax: (670) 664-4813

Board Information

Board Size/Composition	8 / 6 MD, 2 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, DEH

Summary of 2005 Board Actions

State Medical Board of Ohio

77 S. High Street, 17th Floor
Columbus, OH 43215-6127
http://www.med.ohio.gov
(614) 466-3934; Fax: (614) 728-5946

Board Information

Board Size/Composition	7 MD, 1 DO, 3 public, 1 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, ANA, MT, CT

Board Actions	2005	2004	2003	2002	2001	Board Actions	2005	2004	2003	2002	2001
Total Actions	NR*	NR	NR	1	0	Total Actions	280	276	266	311	244
Loss of License or Licensed Privilege	NR	NR	NR	1	0	Loss of License or Licensed Privilege	113	127	105	126	101
Restriction of License or Licensed Privilege	NR	NR	NR	0	0	Restriction of License or Licensed Privilege	122	100	107	121	101
Other Prejudicial Actions	NR	NR	NR	0	0	Other Prejudicial Actions	10	18	30	35	17
Total Prejudicial Actions	NR	NR	NR	1	0	Total Prejudicial Actions	245	245	242	282	219
Non-Prejudicial Actions	NR	NR	NR	0	0	Non-Prejudicial Actions	35	31	24	29	25
Number of Physicians with Prejudicial Actions	NR	NR	NR	1	0	Number of Physicians with Prejudicial Actions	182	193	191	227	170
Number of Physicians with Non-Prejudicial Actions	NR	NR	NR	0	0	Number of Physicians with Non-Prejudicial Actions	39	37	26	32	27
Total Number of Physicians with Actions	NR	NR	NR	1	0	Total Number of Physicians with Actions	213	222	213	252	191
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	NR	NR	NR	NR	NR	Total Number of Licensed Physicians	38,851	38,742	38,332	38,190	34,602
Total Number of Licensed Physicians Practicing In-State	NR	NR	NR	NR	NR	Total Number of Licensed Physicians Practicing In-State	28,942	28,551	27,973	27,738	25,598
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	NA**	NA	NA	NA	NA	Total Actions/Total Licensed Physicians	7.21	7.12	6.94	8.14	7.05
Total Actions/Practicing In-State Physicians	NA	NA	NA	NA	NA	Total Actions/Practicing In-State Physicians	9.67	9.67	9.51	11.21	9.53
Total Prejudicial Actions/Total Licensed Physicians	NA	NA	NA	NA	NA	Total Prejudicial Actions/Total Licensed Physicians	6.31	6.32	6.31	7.38	6.33
Total Prejudicial Actions/Practicing In-State Physicians	NA	NA	NA	NA	NA	Total Prejudicial Actions/Practicing In-State Physicians	8.47	8.58	8.65	10.17	8.56
Composite Action Index	NA	NA	NA	NA	NA	Composite Action Index	7.91	7.92	7.85	9.23	7.87

Oklahoma State Board of Medical Licensure and Supervision

P.O. BOX 18256
Oklahoma City, OK 73118
http://www.okmedicalboard.org
(405) 848-6841; Fax: (404) 848-8240

Board Information

Board Size/Composition	9 / 7 MD, 2 public
Board Meeting Frequency	7 per year
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, PA, RN, PT, DEI

Board Actions	2005	2004	2003	2002	2001
Total Actions	45	47	63	62	65
Loss of License or Licensed Privilege	18	21	32	24	37
Restriction of License or Licensed Privilege	18	16	19	24	18

Summary of 2005 Board Actions

Oklahoma Board of Osteopathic Examiners

4848 N. Lincoln Blvd, Suite 100
Oklahoma City, OK 73105-3321
http://www.docboard.org
(405) 528-8625; Fax: (405) 557-0653

Board Information

Board Size/Composition	8 / 6 DO, 2 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	DO

Board Actions	2005	2004	2003	2002	2001
Total Actions	21	17	13	22	22
Loss of License or Licensed Privilege	4	8	3	11	8

Other Prejudicial Actions	5	2	2	5	3
Total Prejudicial Actions	41	39	53	53	58
Non-Prejudicial Actions	4	8	10	9	7
Number of Physicians with Prejudicial Actions	31	33	42	46	47
Number of Physicians with Non-Prejudicial Actions	5	10	14	17	12
Total Number of Physicians with Actions	35	40	52	53	53
Physician Population					
Total Number of Licensed Physicians	8,280	8,173	8,131	8,004	7,823
Total Number of Licensed Physicians Practicing In-State	5,557	5,483	5,384	5,332	5,362
Composite Action Index					
Total Actions/Total Licensed Physicians	5.43	5.75	7.75	7.75	8.31
Total Actions/Practicing In-State Physicians	8.10	8.57	11.70	11.63	12.12
Total Prejudicial Actions/Total Licensed Physicians	4.95	4.77	6.52	6.62	7.41
Total Prejudicial Actions/Practicing In-State Physicians	7.38	7.11	9.84	9.94	10.82
Composite Action Index	6.47	6.55	8.95	8.98	9.67

Restriction of License or Licensed Privilege	10	8	8	9	11
Other Prejudicial Actions	1	0	1	1	1
Total Prejudicial Actions	15	16	12	21	20
Non-Prejudicial Actions	6	1	1	1	2
Number of Physicians with Prejudicial Actions	12	13	9	17	16
Number of Physicians with Non-Prejudicial Actions	6	4	1	1	2
Total Number of Physicians with Actions	16	14	10	18	18
Physician Population					
Total Number of Licensed Physicians	1,961	1,901	1,784	1,710	1,707
Total Number of Licensed Physicians Practicing In-State	1,453	1,405	1,329	1,259	1,269
Composite Action Index					
Total Actions/Total Licensed Physicians	10.71	8.94	7.29	12.87	12.89
Total Actions/Practicing In-State Physicians	14.45	12.10	9.78	17.47	17.34
Total Prejudicial Actions/Total Licensed Physicians	7.65	8.42	6.73	12.28	11.72
Total Prejudicial Actions/Practicing In-State Physicians	10.32	11.39	9.03	16.68	15.76
Composite Action Index	10.78	10.21	8.21	14.83	14.43

Summary of 2005 Board Actions

Oregon Board of Medical Examiners

1500 SW First Ave, 620 Crown Plaza
Portland, OR 97201-5826
http://egov.oregon.gov/BME
(503) 229-5770; Fax: (503) 229-6543

Board Information

Board Size/Composition	11 / 7 MD, 2 public, 2 other
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, ACU, PA, POD

Board Actions	2005	2004	2003	2002	2001
Total Actions	73	46	64	60	50
Loss of License or Licensed Privilege	33	16	14	19	14
Restriction of License or Licensed Privilege	22	17	32	25	26
Other Prejudicial Actions	9	3	5	6	6
Total Prejudicial Actions	64	36	51	50	46
Non-Prejudicial Actions	9	10	13	10	4
Number of Physicians with Prejudicial Actions	52	35	48	45	40

Summary of 2005 Board Actions

Pennsylvania State Board of Medicine

P.O. BOX 2649
Harrisburg, PA 17105-2649
http://www.dos.state.pa.us
(717) 787-2381; Fax: (717) 787-7769

Board Information

Board Size/Composition	11 / 6 MD, 2 public, 3 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, ACU, PA, NM, RT, AT

Board Actions	2005	2004	2003	2002	2001
Total Actions	194	277	128	128	138
Loss of License or Licensed Privilege	79	107	57	64	68
Restriction of License or Licensed Privilege	30	46	23	17	19
Other Prejudicial Actions	64	95	26	31	38
Total Prejudicial Actions	173	248	106	112	125
Non-Prejudicial Actions	21	29	22	16	13
Number of Physicians with Prejudicial Actions	164	229	101	102	117

Number of Physicians with Non-Prejudicial Actions	11	10	14	10	5
Total Number of Physicians with Actions	58	45	60	54	44
Physician Population					
Total Number of Licensed Physicians	12,670	12,820	12,085	12,355	12,002
Total Number of Licensed Physicians Practicing In-State	10,950	9,509	8,950	10,466	9,726
Composite Action Index					
Total Actions/Total Licensed Physicians	5.76	3.59	5.30	4.86	4.17
Total Actions/Practicing In-State Physicians	6.67	4.84	7.15	5.73	5.14
Total Prejudicial Actions/Total Licensed Physicians	5.05	2.81	4.22	4.05	3.83
Total Prejudicial Actions/Practicing In-State Physicians	5.84	3.79	5.70	4.78	4.73
Composite Action Index	5.83	3.75	5.59	4.85	4.47

Number of Physicians with Non-Prejudicial Actions	22	30	22	15	13
Total Number of Physicians with Actions	179	247	119	115	130
Physician Population					
Total Number of Licensed Physicians	42,477	44,433	42,946	38,439	46,158
Total Number of Licensed Physicians Practicing In-State	31,599	33,000	31,247	29,221	30,292
Composite Action Index					
Total Actions/Total Licensed Physicians	4.57	6.23	2.98	3.33	2.99
Total Actions/Practicing In-State Physicians	6.14	8.39	4.10	4.38	4.56
Total Prejudicial Actions/Total Licensed Physicians	4.07	5.58	2.47	2.91	2.71
Total Prejudicial Actions/Practicing In-State Physicians	5.47	7.52	3.39	3.83	4.13
Composite Action Index	5.06	6.93	3.23	3.61	3.59

Summary of 2005 Board Actions

Pennsylvania State Board of Osteopathic Medicine

P.O. BOX 2649
Harrisburg, PA 17105-2649
http://www.dos.state.pa.us
(717) 783-4858; Fax: (717) 787-7769

Summary of 2005 Board Actions

Puerto Rico Board of Medical Examiners

P.O. BOX 13969
San Juan, PR 00908
(787) 782-8949; Fax: (787) 792-4436

Board Information

Board Size/Composition	9 / 6 DO, 2 public, 1 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO, PA, ACU, RT, AT

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	26	39	33	38	54
Loss of License or Licensed Privilege	9	12	12	9	16
Restriction of License or Licensed Privilege	5	5	5	2	9
Other Prejudicial Actions	11	19	13	20	29
Total Prejudicial Actions	25	36	30	31	54
Non-Prejudicial Actions	1	3	3	7	0
Number of Physicians with Prejudicial Actions	22	36	27	29	51
Number of Physicians with Non-Prejudicial Actions	1	3	3	7	0
Total Number of Physicians with Actions	23	37	30	35	51

Physician Population

Board Information

Board Size/Composition	9 / 9 MD
Board Meeting Frequency	Bimonthly
Standard of Proof Required	
Professions Regulated by Board	MD, DO, VN, SLP

	2005	2004	2003	2002	2001
Board Actions					
Total Actions	NR*	NR	NR	1	NR
Loss of License or Licensed Privilege	NR	NR	NR	1	NR
Restriction of License or Licensed Privilege	NR	NR	NR	0	NR
Other Prejudicial Actions	NR	NR	NR	0	NR
Total Prejudicial Actions	NR	NR	NR	1	NR
Non-Prejudicial Actions	NR	NR	NR	0	NR
Number of Physicians with Prejudicial Actions	NR	NR	NR	1	NR
Number of Physicians with Non-Prejudicial Actions	NR	NR	NR	0	NR
Total Number of Physicians with Actions	NR	NR	NR	1	NR
Physician Population					
Total Number of Licensed Physicians	NR	NR	NR	NR	NR

Total Number of Licensed Physicians	6,226	6,288	6,163	5,701	6,541
Total Number of Licensed Physicians Practicing In-State	4,904	4,712	4,711	4,472	4,439
Composite Action Index					
Total Actions/Total Licensed Physicians	4.18	6.20	5.35	6.67	8.26
Total Actions/Practicing In-State Physicians	5.30	8.28	7.00	8.50	12.16
Total Prejudicial Actions/Total Licensed Physicians	4.02	5.73	4.87	5.44	8.26
Total Prejudicial Actions/Practicing In-State Physicians	5.10	7.64	6.37	6.93	12.16
Composite Action Index	4.65	6.96	5.90	6.88	10.21

Total Number of Licensed Physicians Practicing In-State	NR	NR	NR	NR	NR
Composite Action Index					
Total Actions/Total Licensed Physicians	NA**	NA	NA	NA	NA
Total Actions/Practicing In-State Physicians	NA	NA	NA	NA	NA
Total Prejudicial Actions/Total Licensed Physicians	NA	NA	NA	NA	NA
Total Prejudicial Actions/Practicing In-State Physicians	NA	NA	NA	NA	NA
Composite Action Index	NA	NA	NA	NA	NA

*Not Reported **Not Applicable

Rhode Island Board of Medical Licensure and Discipline

Department of Health

Cannon Building, Room 205, Three Capitol Hill
Providence, RI 02908-5097
http://www.health.ri.gov/hsr/bmld
(401) 222-3855; Fax: (401) 222-2158

Board Information

Board Size/Composition	12/ 4 MD, 2 public, 6 other

Summary of 2005 Board Actions

South Carolina Board of Medical Examiners

Department of Labor, Licensing and Regulation

110 Centerview Dr., Suite 202
Columbia, SC 29210-1289
http://www.llr.state.sc.us/pol/medical
(803) 896-4500; Fax: (803) 896-4515

Board Information

Board Size/Composition	10 / 8 MD, 1 DO, 1 public

Board Meeting Frequency	Monthly					Board Meeting Frequency	Quarterly					
Standard of Proof Required	Preponderance of the Evidence					Standard of Proof Required	Preponderance of the Evidence					
Professions Regulated by Board	MD, DO					Professions Regulated by Board	MD, DO, ACU, PA, RT, ANA, CIS					
Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**	**Board Actions**	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	17	20	11	13	10	Total Actions	26	30	58	35	35
Loss of License or Licensed Privilege	4	8	5	8	5	Loss of License or Licensed Privilege	13	14	25	15	12
Restriction of License or Licensed Privilege	12	2	2	2	2	Restriction of License or Licensed Privilege	2	3	8	3	2
Other Prejudicial Actions	1	9	4	0	3	Other Prejudicial Actions	11	10	16	13	10
Total Prejudicial Actions	17	19	11	10	10	Total Prejudicial Actions	26	27	49	31	24
Non-Prejudicial Actions	0	1	0	3	0	Non-Prejudicial Actions	0	3	9	4	11
Number of Physicians with Prejudicial Actions	15	19	9	9	8	Number of Physicians with Prejudicial Actions	24	23	41	28	23
Number of Physicians with Non-Prejudicial Actions	0	1	0	3	0	Number of Physicians with Non-Prejudicial Actions	0	3	10	4	11
Total Number of Physicians with Actions	15	19	9	12	8	Total Number of Physicians with Actions	24	26	46	32	27
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	4,191	4,313	4,000	3,870	4,034	Total Number of Licensed Physicians		13,267	12,915	13,339	12,939
Total Number of Licensed Physicians Practicing In-State	3,229	3,301	4,000	2,915	3,008	Total Number of Licensed Physicians Practicing In-State		8,974	8,851	9,320	9,188
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	4.06	4.64	2.75	3.36	2.48	Total Actions/Total Licensed Physicians		2.26	4.49	2.62	2.71
Total Actions/Practicing In-	5.26	6.06	2.75	4.46	3.32	Total Actions/Practicing In-		3.34	6.55	3.76	3.81

State Physicians						State Physicians					
Total Prejudicial Actions/Total Licensed Physicians	4.06	4.41	2.75	2.58	2.48	Total Prejudicial Actions/Total Licensed Physicians	2.04	3.79	2.32	1.85	
Total Prejudicial Actions/Practicing In-State Physicians	5.26	5.76	2.75	3.43	3.32	Total Prejudicial Actions/Practicing In-State Physicians	3.01	5.54	3.33	2.61	
Composite Action Index	4.66	5.21	2.75	3.46	2.90	Composite Action Index	2.66	5.09	3.01	2.75	

Summary of 2005 Board Actions

South Dakota Board of Medical and Osteopathic Examiners

123 S. Main Ave., Suite 100
Sioux Falls, SD 57104
http://www.state.sd.us/doh/medical
(605) 367-7781

Board Information	
Board Size/Composition	9 / 6 MD, 1 DO, 2 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, PA, NP, AT, DEI, EMT, MA, MC, MR, NM, NUT, OT, OTA, PAC, PT, PTA, RT

Board Actions	2005	2004	2003	2002	2001
Total Actions	2	7	11	5	4
Loss of License or Licensed Privilege	1	2	5	3	0

Summary of 2005 Board Actions

Tennessee Board of Medical Examiners

425 5th Ave. North, 1st Floor, Cordell Hull Building
Nashville, TN 37247-1010
http://www.state.tn.us/health/boards/me/index.htm
(615) 532-3202; Fax: (615) 253-4484

Board Information	
Board Size/Composition	12 / 9 MD, 3 public
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, ACU, PA, CP

Board Actions	2005	2004	2003	2002	2001
Total Actions	85	61	56	29	48
Loss of License or Licensed Privilege	38	39	24	11	20

Restriction of License or Licensed Privilege	0	2	2	1	2	Restriction of License or Licensed Privilege	27	10	17	12	15
Other Prejudicial Actions	1	2	2	0	1	Other Prejudicial Actions	13	7	9	0	5
Total Prejudicial Actions	2	6	9	4	3	Total Prejudicial Actions	78	56	50	23	40
Non-Prejudicial Actions	0	1	2	1	1	Non-Prejudicial Actions	7	5	6	6	8
Number of Physicians with Prejudicial Actions	2	5	8	3	3	Number of Physicians with Prejudicial Actions	72	53	46	25	36
Number of Physicians with Non-Prejudicial Actions	0	1	2	1	1	Number of Physicians with Non-Prejudicial Actions	7	5	6	9	8
Total Number of Physicians with Actions	2	6	9	4	4	Total Number of Physicians with Actions	76	58	50	29	44
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	2,968	2,747	2,584	2,736	2,637	Total Number of Licensed Physicians	18,288	17,894	17,521	17,551	17,338
Total Number of Licensed Physicians Practicing In-State	1,768	1,595	1,543	1,632	2,455	Total Number of Licensed Physicians Practicing In-State 14,210		NR*	13,581	10,645	10,748
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	0.67	2.55	4.26	1.83	1.52	Total Actions/Total Licensed Physicians	4.65	3.41	3.20	1.65	2.77
Total Actions/Practicing In-State Physicians	1.13	4.39	7.13	3.06	1.63	Total Actions/Practicing In-State Physicians	5.98	NA**	4.12	2.72	4.47
Total Prejudicial Actions/Total Licensed Physicians	0.67	2.18	3.48	1.46	1.14	Total Prejudicial Actions/Total Licensed Physicians	4.27	2.85	1.31	2.31	3.13
Total Prejudicial Actions/Practicing In-State Physicians	1.13	3.76	5.83	2.45	1.22	Total Prejudicial Actions/Practicing In-State Physicians	5.49	NA	3.68	2.16	3.72
Composite Action Index	0.90	3.22	5.18	2.20	1.38	Composite Action Index	5.10	NA	3.46	1.96	3.32

*Not Reported **Not Applicable

Summary of 2005 Board Actions

Tennessee Board of Osteopathic Examiners

425 5th Ave. North, 1st Floor, Cordell Hull Building
Nashville, TN 37247-1010
http://www.state.tn.us/health/professions
(615) 532-3202; Fax: (615) 253-4484

Board Information

Board Size/Composition	6 / 5 DO, 1 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO, NM

Board Actions	2005	2004	2003	2002	2001
Total Actions	5	1	0	0	3
Loss of License or Licensed Privilege	4	1	0	0	1
Restriction of License or Licensed Privilege	0	0	0	0	2
Other Prejudicial Actions	1	0	0	0	0
Total Prejudicial Actions	5	1	0	0	3
Non-Prejudicial Actions	0	0	0	0	0
Number of Physicians with	5	1	0	0	2

Summary of 2005 Board Actions

Texas Medical Board

P.O. BOX 2018

Austin, TX 78701
http://www.tmb.state.tx.us/
(512) 305-7010; Fax: (512) 305-7008

Board Information

Board Size/Composition	19 / 9 MD, 3 DO, 7 public
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, DO, ACU, PA, CP

Board Actions	2005	2004	2003	2002	2001
Total Actions	448	311	387	283	241
Loss of License or Licensed Privilege	87	72	94	84	50
Restriction of License or Licensed Privilege	101	80	91	79	74
Other Prejudicial Actions	228	131	174	99	96
Total Prejudicial Actions	416	283	359	262	221
Non-Prejudicial Actions	32	28	28	21	20
Number of Physicians with	380	265	334	229	201

Prejudicial Actions					
Number of Physicians with Non-Prejudicial Actions	0	0	0	0	0
Total Number of Physicians with Actions	5	1	0	0	2
Physician Population					
Total Number of Licensed Physicians	688	654	630	599	571
Total Number of Licensed Physicians Practicing In-State	426	NR*	379	253	234
Composite Action Index					
Total Actions/Total Licensed Physicians	7.27	1.53	NA	NA	5.25
Total Actions/Practicing In-State Physicians	11.74	NA**	NA	NA	12.82
Total Prejudicial Actions/Total Licensed Physicians	7.27	NA	NA	5.25	1.53
Total Prejudicial Actions/Practicing In-State Physicians	11.74	NA	NA	NA	12.82
Composite Action Index	9.50	NA	NA	NA	9.04

*Not Reported **Not Appli cable

Prejudicial Actions					
Number of Physicians with Non-Prejudicial Actions	36	30	29	24	25
Total Number of Physicians with Actions	411	290	360	247	220
Physician Population					
Total Number of Licensed Physicians	54,855	53,647	51,073	49,980	49,184
Total Number of Licensed Physicians Practicing In-State	42,022	40,785	39,512	37,188	35,618
Composite Action Index					
Total Actions/Total Licensed Physicians	8.17	5.80	7.58	5.66	4.90
Total Actions/Practicing In-State Physicians	10.66	7.63	9.79	7.61	6.77
Total Prejudicial Actions/Total Licensed Physicians	7.58	5.28	7.03	5.24	4.49
Total Prejudicial Actions/Practicing In-State Physicians	9.90	6.94	9.09	7.05	6.20
Composite Action Index	9.08	6.41	8.37	6.39	5.59

Summary of 2005 Board Actions

Utah Physicians Licensing Board

Physicians Licensing Board

160 E. 300 South, Herbert M. Wells Building, 4th Floor

Summary of 2005 Board Actions

Utah Osteopathic Physician and Surgeons Licensing Board

Board of Osteopathic Medicine

160 E. 300 South, Herbert M. Wells Building, 4th Floor

Salt Lake City, UT 84114
http://www.dopl.utah.gov
(801) 530-6628; Fax: (801) 530-6511

Board Information	
Board Size/Composition	11 / 9 MD, 2 public
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	42	30	46	39	34
Loss of License or Licensed Privilege	10	5	5	9	9
Restriction of License or Licensed Privilege	22	17	30	22	19
Other Prejudicial Actions	1	1	2	2	0
Total Prejudicial Actions	33	23	37	33	28
Non-Prejudicial Actions	9	7	9	6	6
Number of Physicians with Prejudicial Actions	25	16	29	27	17
Number of Physicians with Non-Prejudicial Actions	10	7	10	6	7
Total Number of Physicians with Actions	31	22	33	33	22

Physician Population					
Total Number of Licensed	7,616	7,160	7,332	6,910	7,107

Salt Lake City, UT 84114
http://www.dopl.utah.gov
(801) 530-6628; Fax: (801) 530-6511

Board Information	
Board Size/Composition	5 / 4 DO, 1 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	9	1	0	3	1
Loss of License or Licensed Privilege	2	0	0	0	1
Restriction of License or Licensed Privilege	4	1	0	3	0
Other Prejudicial Actions	2	0	0	0	0
Total Prejudicial Actions	8	1	0	3	1
Non-Prejudicial Actions	1	0	0	0	0
Number of Physicians with Prejudicial Actions	6	1	0	2	1
Number of Physicians with Non-Prejudicial Actions	3	0	0	0	0
Total Number of Physicians with Actions	7	1	0	2	1

Physician Population					
Total Number of Licensed	255	254	238	210	203

Physicians					
Total Number of Licensed Physicians Practicing In-State	NR*	NR	NR	NR	5,408
Composite Action Index					
Total Actions/Total Licensed Physicians	5.51	4.19	6.27	5.64	4.78
Total Actions/Practicing In-State Physicians	NA**	NA	NA	NA	6.29
Total Prejudicial Actions/Total Licensed Physicians	3.94	4.33	3.21	5.05	4.78
Total Prejudicial Actions/Practicing In-State Physicians	NA	NA	NA	NA	5.18
Composite Action Index	NA	NA	NA	NA	5.05

*Not Reported **Not Applicable

Physicians					
Total Number of Licensed Physicians Practicing In-State	NR*	NR	NR	NR	189
Composite Action Index					
Total Actions/Total Licensed Physicians	35.29	3.94	0.00	14.29	4.93
Total Actions/Practicing In-State Physicians	NA**	NA	NA	NA	5.29
Total Prejudicial Actions/Total Licensed Physicians	4.93	31.37	3.94	0.00	14.29
Total Prejudicial Actions/Practicing In-State Physicians	NA	NA	NA	NA	5.29
Composite Action Index	NA	NA	NA	NA	5.11

*Not Reported **Not Applicable

Summary of 2005 Board Actions

Vermont Board of Medical Practice

108 Cherry Street
Burlington, VT 05402-0070
http://www.healthyvermonters.info/bmp/bmp.shtml
(802) 657-4220; Fax: (802) 657-4227

Board Information

Board Size/Composition	17 / 9 MD, 6 public, 1 PA, 1 POD

Summary of 2005 Board Actions

Vermont Board of Osteopathic Physicians and Surgeons

Office of Professional Regulation

26 Terrace Street, Drawer 09
Montpelier, VT 05609-1106
http://vtprofessionals.org
(802) 828-2373; Fax: (802) 828-2465

Board Information

Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, POD, PA, ANA

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	31	14	27	12	8
Loss of License or Licensed Privilege	7	3	12	5	5
Restriction of License or Licensed Privilege	7	5	6	2	0
Other Prejudicial Actions	11	4	7	3	2
Total Prejudicial Actions	25	12	25	10	7
Non-Prejudicial Actions	6	2	2	2	1
Number of Physicians with Prejudicial Actions	17	10	18	9	7
Number of Physicians with Non-Prejudicial Actions	6	2	2	2	1
Total Number of Physicians with Actions	21	12	20	11	8
Physician Population					
Total Number of Licensed Physicians	3,095	2,876	3,054	2,815	3,301
Total Number of Licensed Physicians Practicing In-State	1,855	1,786	1,822	1,745	2,003

Board Size/Composition	5 / 3 DO, 2 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO, MA, PA, POD

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	2	1	0	1	2
Loss of License or Licensed Privilege	1	0	0	0	1
Restriction of License or Licensed Privilege	0	0	0	0	0
Other Prejudicial Actions	1	1	0	1	1
Total Prejudicial Actions	2	1	0	1	2
Non-Prejudicial Actions	0	0	0	0	0
Number of Physicians with Prejudicial Actions	2	1	0	1	2
Number of Physicians with Non-Prejudicial Actions	0	0	0	0	0
Total Number of Physicians with Actions	2	1	0	1	2
Physician Population					
Total Number of Licensed Physicians	99	86	87	81	104
Total Number of Licensed	52	NR*	45	42	45

Composite Action Index					
Total Actions/Total Licensed Physicians	10.02	4.87	8.84	4.26	2.42
Total Actions/Practicing In-State Physicians	16.71	7.84	14.82	6.88	3.99
Total Prejudicial Actions/Total Licensed Physicians	8.08	4.17	8.19	3.55	2.12
Total Prejudicial Actions/Practicing In-State Physicians	13.48	6.72	13.72	5.73	3.49
Composite Action Index	12.07	5.90	11.39	5.11	3.01

	Physicians Practicing In-State				
Composite Action Index					
Total Actions/Total Licensed Physicians	20.20	11.63	0.00	12.35	19.23
Total Actions/Practicing In-State Physicians	38.46	NA**	0.00	23.81	44.44
Total Prejudicial Actions/Total Licensed Physicians	20.20	0.00	12.35	19.23	11.63
Total Prejudicial Actions/Practicing In-State Physicians	38.46	NA	0.00	23.81	44.44
Composite Action Index	29.33	NA	0.00	18.08	31.84

*Not Reported **Not Applicable

Summary of 2005 Board Actions

Vermont Board of Medical Practice

108 Cherry Street
Burlingon, VT 05402-0070
http://www.healthyvermonters.info/bmp/bmp.shtml
(802) 657-4220; Fax: (802) 657-4227

Board Information

Board Size/Composition	17 / 9 MD, 6 public, 1 PA, 1 POD
Board Meeting	Monthly

Summary of 2005 Board Actions

Vermont Board of Osteopathic Physicians and Surgeons

Office of Professional Regulation
26 Terrace Street, Drawer 09
Montpelier, VT 05609-1106
http://vtprofessionals.org
(802) 828-2373; Fax: (802) 828-2465

Board Information

Board Size/Composition	5 / 3 DO, 2 public

Frequency	
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, POD, PA, ANA

Board Actions	2005	2004	2003	2002	2001
Total Actions	31	14	27	12	8
Loss of License or Licensed Privilege	7	3	12	5	5
Restriction of License or Licensed Privilege	7	5	6	2	0
Other Prejudicial Actions	11	4	7	3	2
Total Prejudicial Actions	25	12	25	10	7
Non-Prejudicial Actions	6	2	2	2	1
Number of Physicians with Prejudicial Actions	17	10	18	9	7
Number of Physicians with Non-Prejudicial Actions	6	2	2	2	1
Total Number of Physicians with Actions	21	12	20	11	8
Physician Population					
Total Number of Licensed Physicians	3,095	2,876	3,054	2,815	3,301
Total Number of Licensed Physicians Practicing In-State	1,855	1,786	1,822	1,745	2,003

Size/Composition	
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO, MA, PA, POD

Board Actions	2005	2004	2003	2002	2001
Total Actions	2	1	0	1	2
Loss of License or Licensed Privilege	1	0	0	0	1
Restriction of License or Licensed Privilege	0	0	0	0	0
Other Prejudicial Actions	1	1	0	1	1
Total Prejudicial Actions	2	1	0	1	2
Non-Prejudicial Actions	0	0	0	0	0
Number of Physicians with Prejudicial Actions	2	1	0	1	2
Number of Physicians with Non-Prejudicial Actions	0	0	0	0	0
Total Number of Physicians with Actions	2	1	0	1	2
Physician Population					
Total Number of Licensed Physicians	99	86	87	81	104
Total Number of Licensed Physicians Practicing In-	52	NR*	45	42	45

Composite Action Index					
Total Actions/Total Licensed Physicians	10.02	4.87	8.84	4.26	2.42
Total Actions/Practicing In-State Physicians	16.71	7.84	14.82	6.88	3.99
Total Prejudicial Actions/Total Licensed Physicians	8.08	4.17	8.19	3.55	2.12
Total Prejudicial Actions/Practicing In-State Physicians	13.48	6.72	13.72	5.73	3.49
Composite Action Index	12.07	5.90	11.39	5.11	3.01

	State				
Composite Action Index					
Total Actions/Total Licensed Physicians	20.20	11.63	0.00	12.35	19.23
Total Actions/Practicing In-State Physicians	38.46	NA**	0.00	23.81	44.44
Total Prejudicial Actions/Total Licensed Physicians	20.20	0.00	12.35	19.23	11.63
Total Prejudicial Actions/Practicing In-State Physicians	38.46	NA	0.00	23.81	44.44
Composite Action Index	29.33	NA	0.00	18.08	31.84

*Not Reported **Not Applicable

Summary of 2005 Board Actions

Virgin Islands Board of Medical Examiners

Department of Health
48 Sugar Estate
St. Thomas, VI 00802
(340) 774-0117; Fax: (340) 777-4001

Board Information

Board Size/Composition	5 / 5 MD
Board Meeting Frequency	Quarterly

Summary of 2005 Board Actions

Virginia Board of Medicine

6603 W. Broad St, 5th Floor
Richmond, VA 23230-1717
http://www.dhp.state.va.us
(804) 662-9908; Fax: (804) 662-9517

Board Information

Board Size/Composition	18 / 11 MD, 1 DO, 4 public, 1 DPM, 1 CHI
Board Meeting Frequency	Three full board meetings annually (special committees hold

Standard of Proof Required	
Professions Regulated by Board	MD, DO

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	0	0	0	0	0
Loss of License or Licensed Privilege	0	0	0	0	0
Restriction of License or Licensed Privilege	0	0	0	0	0
Other Prejudicial Actions	0	0	0	0	0
Total Prejudicial Actions	0	0	0	0	0
Non-Prejudicial Actions	0	0	0	0	0
Number of Physicians with Prejudicial Actions	0	0	0	0	0
Number of Physicians with Non-Prejudicial Actions	0	0	0	0	0
Total Number of Physicians with Actions	0	0	0	0	0
Physician Population					
Total Number of Licensed Physicians	241	155	235	NR*	NR
Total Number of Licensed Physicians Practicing In-State	222	141	203	NR	NR

Composite Action Index

disciplinary hearings most weeks)

Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, DO, PA, ACU, AT, CHI, NM, OT, POD, RT, NP, NA, RT, RTL

Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	164	148	145	137	99
Loss of License or Licensed Privilege	49	43	42	47	53
Restriction of License or Licensed Privilege	15	14	15	17	15
Other Prejudicial Actions	62	59	49	43	15
Total Prejudicial Actions	126	116	106	107	83
Non-Prejudicial Actions	38	32	39	30	16
Number of Physicians with Prejudicial Actions	120	107	94	104	78
Number of Physicians with Non-Prejudicial Actions	38	32	39	30	16
Total Number of Physicians with Actions	135	116	124	122	87
Physician Population					
Total Number of Licensed Physicians	31,379	29,304	30,528	28,589	29,629
Total Number of Licensed Physicians Practicing In-State	18,131	17,395	17,654	16,937	17,402

Total Actions/Total Licensed Physicians	NA**	0.00	0.00	NA	NA
Total Actions/Practicing In-State Physicians	NA	0.00	0.00	NA	NA
Total Prejudicial Actions/Total Licensed Physicians	NA	0.00	0.00	NA	NA
Total Prejudicial Actions/Practicing In-State Physicians	NA	0.00	0.00	NA	NA
Composite Action Index	NA	0.00	0.00	NA	NA

*Not Reported **Not Applicable

Composite Action Index

Total Actions/Total Licensed Physicians	5.23	5.05	4.75	4.79	3.34
Total Actions/Practicing In-State Physicians	9.05	8.51	8.21	8.09	5.69
Total Prejudicial Actions/Total Licensed Physicians	4.02	3.96	3.47	3.74	2.80
Total Prejudicial Actions/Practicing In-State Physicians	6.95	6.67	6.00	6.32	4.77
Composite Action Index	6.31	6.05	5.61	5.74	4.15

Summary of 2005 Board Actions

Washington Medical Quality Assurance Commission

Department of Health

310 Israel Road, SE, MS 47866

Tumwater, WA 98501

http://www.doh.wa.gov

(360) 236-4788; Fax: (360) 586-4573

Board Information

Board Size/Composition	19 / 13 MD, 4 public, 2 other
Board Meeting Frequency	Every six weeks
Standard of Proof Required	Clear and Convincing

Summary of 2005 Board Actions

Washington Board of Osteopathic Medicine and Surgery

Department of Health

P.O. BOX 47866

Olympia, WA 98504-7866

http://www.doh.wa.gov

(360) 236-4945; Fax: (360) 236-2406

Board Information

Board Size/Composition	7 / 6 DO, 1 public
Board Meeting Frequency	Quarterly
Standard of Proof Required	Preponderance of the Evidence

Professions Regulated by Board	MD					Professions Regulated by Board	DO, PA				
Board Actions	**2005**	**2004**	**2003**	**2002**	**2001**	**Board Actions**	**2005**	**2004**	**2003**	**2002**	**2001**
Total Actions	92	82	90	63	59	Total Actions	8	5	2	4	3
Loss of License or Licensed Privilege	18	15	23	13	11	Loss of License or Licensed Privilege	2	2	0	1	0
Restriction of License or Licensed Privilege	23	19	24	22	25	Restriction of License or Licensed Privilege	3	0	2	1	2
Other Prejudicial Actions	28	30	27	11	12	Other Prejudicial Actions	1	3	0	2	1
Total Prejudicial Actions	69	64	74	46	48	Total Prejudicial Actions	6	5	2	4	3
Non-Prejudicial Actions	23	18	16	17	11	Non-Prejudicial Actions	2	0	0	0	0
Number of Physicians with Prejudicial Actions	64	58	65	41	43	Number of Physicians with Prejudicial Actions	6	5	2	4	3
Number of Physicians with Non-Prejudicial Actions	23	18	16	17	10	Number of Physicians with Non-Prejudicial Actions	3	0	0	0	0
Total Number of Physicians with Actions	83	75	81	57	52	Total Number of Physicians with Actions	7	5	2	4	3
Physician Population						**Physician Population**					
Total Number of Licensed Physicians	20,623	20,026	19,652	19,253	19,661	Total Number of Licensed Physicians	824	765	744	719	690
Total Number of Licensed Physicians Practicing In-State	15,156	14,811	14,531	14,261	14,634	Total Number of Licensed Physicians Practicing In-State	615	586	580	539	520
Composite Action Index						**Composite Action Index**					
Total Actions/Total Licensed Physicians	4.46	4.09	4.58	3.27	3.00	Total Actions/Total Licensed Physicians	9.71	6.54	2.69	5.56	4.35
Total Actions/Practicing In-State Physicians	6.07	5.54	6.19	4.42	4.03	Total Actions/Practicing In-State Physicians	13.01	8.53	3.45	7.42	5.77
Total Prejudicial Actions/Total Licensed	3.35	3.20	3.77	2.39	2.44	Total Prejudicial Actions/Total Licensed Physicians	7.28	6.54	2.69	5.56	4.35

Physicians											
Total Prejudicial Actions/Practicing In-State Physicians	4.55	4.32	5.09	3.23	3.28	Total Prejudicial Actions/Practicing In-State Physicians	9.76	8.53	3.45	7.42	5.77
Composite Action Index	4.61	4.29	4.91	3.33	3.19	Composite Action Index	9.94	7.53	3.07	6.49	5.06

Summary of 2005 Board Actions

West Virginia Board of Medicine

101 Dee Drive
Charleston, WV 25311
http://www.wvdhhr.org/wvbom
(304) 558-2921; Fax: (304) 558-2084

Board Information

Board Size/Composition	15 / 9 MD, 3 Public, 3 other
Board Meeting Frequency	Bimonthly
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, PA, POD

Board Actions	2005	2004	2003	2002	2001
Total Actions	65	42	48	36	36
Loss of License or Licensed Privilege	18	10	20	15	13
Restriction of License or Licensed Privilege	7	9	10	7	8

Summary of 2005 Board Actions

West Virginia Board of Osteopathy

334 Penco Rd, WEIRTON WV 26062
Weirton, WV 26062
http://www.wvbdosteo.org/
(304) 723-4638; Fax: (304) 723-2877

Board Information

Board Size/Composition	5 / 3 DO, and 2 public
Board Meeting Frequency	3 -4 per year
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	DO

Board Actions	2005	2004	2003	2002	2001
Total Actions	6	7	7	5	4
Loss of License or Licensed Privilege	2	4	2	2	3
Restriction of License or Licensed Privilege	3	2	2	0	0

Other Prejudicial Actions	24	11	10	8	7
Total Prejudicial Actions	49	30	40	30	28
Non-Prejudicial Actions	16	12	8	6	8
Number of Physicians with Prejudicial Actions	48	27	38	26	27
Number of Physicians with Non-Prejudicial Actions	15	12	8	6	8
Total Number of Physicians with Actions	50	33	43	32	34
Physician Population					
Total Number of Licensed Physicians	5,815	5,726	5,813	6,100	6,193
Total Number of Licensed Physicians Practicing In-State	3,650	3,532	3,575	3,552	3,570
Composite Action Index					
Total Actions/Total Licensed Physicians	11.18	7.33	8.26	5.90	5.81
Total Actions/Practicing In-State Physicians	17.81	11.89	13.43	10.14	10.08
Total Prejudicial Actions/Total Licensed Physicians	8.43	5.24	6.88	4.92	4.52
Total Prejudicial Actions/Practicing In-State Physicians	13.42	8.49	11.19	8.45	7.84
Composite Action Index	12.71	8.24	9.94	7.35	7.07

Other Prejudicial Actions	0	0	1	2	0
Total Prejudicial Actions	5	6	5	4	3
Non-Prejudicial Actions	1	1	2	1	1
Number of Physicians with Prejudicial Actions	5	5	5	4	3
Number of Physicians with Non-Prejudicial Actions	1	1	3	1	1
Total Number of Physicians with Actions	6	6	7	4	4
Physician Population					
Total Number of Licensed Physicians	825	810	836	861	839
Total Number of Licensed Physicians Practicing In-State	607	572	541	525	499
Composite Action Index					
Total Actions/Total Licensed Physicians	7.27	8.64	8.37	5.81	4.77
Total Actions/Practicing In-State Physicians	9.88	12.24	12.94	9.52	8.02
Total Prejudicial Actions/Total Licensed Physicians	6.06	7.41	5.98	4.65	3.58
Total Prejudicial Actions/Practicing In-State Physicians	8.24	10.49	9.24	7.62	6.01
Composite Action Index	7.86	9.69	9.13	6.90	5.59

1400 E. Washington Ave
Madison, WI 53703
http://www.drl.state.wi.us/
(608) 266-2112; Fax: (608) 261-7083

Board Information

Board Size/Composition	14 / 9 MD, 1 DO, 3 public, 1 other
Board Meeting Frequency	Monthly
Standard of Proof Required	Preponderance of the Evidence
Professions Regulated by Board	MD, D0, PA, RT

Board Actions	2005	2004	2003	2002	2001
Total Actions	105	113	105	82	109
Loss of License or Licensed Privilege	16	19	17	16	15
Restriction of License or Licensed Privilege	7	14	8	4	10
Other Prejudicial Actions	65	67	66	53	70
Total Prejudicial Actions	88	100	91	73	95
Non-Prejudicial Actions	17	13	14	9	14
Number of Physicians with Prejudicial Actions	61	59	49	38	60
Number of Physicians with Non-Prejudicial Actions	16	13	13	9	13

Cheyenne, WY 82002
http://wyomedboard.state.wy.us
(307) 778-7053; Fax: (307) 778-2069

Board Information

Board Size/Composition	8 / 4 MD, 1 DO, 2 public, 1 other
Board Meeting Frequency	3 per year
Standard of Proof Required	Clear and Convincing
Professions Regulated by Board	MD, DO, PA

Board Actions	2005	2004	2003	2002	2001
Total Actions	10	12	24	17	4
Loss of License or Licensed Privilege	4	2	10	9	0
Restriction of License or Licensed Privilege	3	6	3	3	2
Other Prejudicial Actions	2	0	7	4	1
Total Prejudicial Actions	9	8	20	16	3
Non-Prejudicial Actions	1	4	4	1	1
Number of Physicians with Prejudicial Actions	7	9	19	12	3
Number of Physicians with Non-Prejudicial Actions	1	4	4	1	2
Total Number of	7	12	20	12	4

Non-Prejudicial Actions					
Total Number of Physicians with Actions	69	67	53	43	65
Physician Population					
Total Number of Licensed Physicians	20,838	21,322	19,856	19,868	33,874
Total Number of Licensed Physicians Practicing In-State	14,228	19,158	13,546	13,222	17,559
Composite Action Index					
Total Actions/Total Licensed Physicians	5.04	5.30	5.29	4.13	3.22
Total Actions/Practicing In-State Physicians	7.38	5.90	7.75	6.20	6.21
Total Prejudicial Actions/Total Licensed Physicians	4.22	4.69	4.58	3.67	2.80
Total Prejudicial Actions/Practicing In-State Physicians	6.18	5.22	6.72	5.52	5.41
Composite Action Index	5.71	5.28	6.09	4.88	4.41

Physicians with Actions					
Physician Population					
Total Number of Licensed Physicians	2,439	2,447	2,353	2,277	2,275
Total Number of Licensed Physicians Practicing In-State	1,037	814	934	881	988
Composite Action Index					
Total Actions/Total Licensed Physicians	4.10	4.90	10.20	7.47	1.76
Total Actions/Practicing In-State Physicians	9.64	14.74	25.70	19.30	4.05
Total Prejudicial Actions/Total Licensed Physicians	3.69	3.27	8.50	7.03	1.32
Total Prejudicial Actions/Practicing In-State Physicians	8.68	9.83	21.41	18.16	3.04
Composite Action Index	6.53	8.19	16.45	12.99	2.54

About the Federation of State Medical Boards

The FSMB: Helping Medical Boards Fulfill Mandate to Protect the Public

State medical boards work together on issues relevant to all of them through the Dallas-based Federation of State Medical Boards, which was founded in 1912.The FSMB provides an array of services, several of which are described below, to assist medical boards in their mission of protecting the public from the incompetent or unprofessional practice of medicine.

Policy Development and Dissemination

In the past two years, the FSMB has played a key role in state and national debates on many prominent issues, including Internet prescribing, telemedicine, alternative medicine, oversight of resident physicians and management of chronic pain. The FSMB monitors federal and state legislation that impacts medical regulation.As the national authority on issues regarding medical licensure and discipline, the FSMB is often called upon to offer testimony before Congress, federal agencies and state legislatures. The FSMB identifies legislative trends, develops model medical regulatory policies, facilitates communication between states on legislative issues, drafts statutory language and legislative testimony and assists with legislative strategies.

Physician Data

The FSMB was the first group to publish and distribute the names of the country's disciplined physicians. That information is now disseminated electronically via the Federation Physician Data Center, a repository of licensure data on more than 700,000 U.S. physicians that contains more than 156,000 disciplinary actions against 46,000 physicians dating to the 1960s. The Data Center receives regular updates from medical boards when they take disciplinary actions.An alert service provided by the Data Center means medical boards can quickly identify disciplined physicians who seek to relocate to another jurisdiction without detection. A similar service advises hospitals and managed care organizations when one of their physicians has been disciplined. The public can access nationally consolidated information about a physician from www.docinfo.org for a nominal fee.

United States Medical Licensing Examination

Medical licensing authorities in the United States require each applicant for licensure to pass an examination to ensure the physician is competent to practice medicine safely. The FSMB and the National Board of Medical Examiners administer the United States Medical Licensing Examination (USMLE), a three-step examination designed to be taken at different points during medical education and training. The USMLE evaluates a physician’s ability to apply medical knowledge, concepts and principles to patient care and management across multiple settings. It also tests an applicant’s clinical and communications skills in situations that replicate a doctor’s typical mix of cases in a busy medical clinic.

Credentials Verification

Established in 1996 at the request of the FSMB's member boards as a tool to facilitate license portability, the Federation Credentials Verification Service (FCVS) is a permanent repository of core medical credentials for physicians and physician assistants, including medical education, postgraduate training, examination history, board action history, board certification and identity. Because FCVS provides primary source verification, this process eliminates the potential for fraudulent documentation and lessens the duplicative credentialing activities among medical boards that participate in the service. These credentials are subsequently available at a physician's request whenever he or she seeks licensure in another jurisdiction. Currently, 60,000 physicians have profiles with FCVS.

To learn more about the FSMB, please visit www.fsmb.org.

The Federation of State Medical Boards
P.O. Box 619850
Dallas,Texas 75261-9850
(817) 868-4000
www.fsmb.org

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Appendix VI: Organizations that Declined or Made No Comment

- Listing of the organizations
- Letters, E-mails, and faxes for these organizations

Hospitals that Declined
GARFIELD MEDICAL CENTER

Health Plans that Declined
Blue Cross of California
Partnership HealthPlan of California
TRICARE SENIOR PRIME

Medical Groups that Declined
Bright Medical Associates
Centre For Health Care
Key Medical Group, Inc.
Medcore Medical Group aka HP/Omni IPA
San Jose Medical Group
Sansum Santa Barbara Medical Foundation
Solano/Sutter Delta/Sutter Fairfield MG
St. Francis IPA Medical Group

Hospitals with no contact
CENTURY CITY HOSPITAL
CHILDREN'S HOSPITAL CENTRAL CALIFORNIA
CHINO VALLEY MEDICAL CENTER
EL CENTRO REGIONAL MEDICAL CENTER
FALLBROOK HOSPITAL DISTRICT
LAC/OLIVE VIEW-UCLA MEDICAL CENTER
LAGUNA HONDA HOSPITAL & REHAB CENTER
LITTLE COMPANY OF MARY HOSPITAL
PARADISE VALLEY HOSPITAL
PIONEERS MEMORIAL HOSPITAL
SAN CLEMENTE HOSPITAL & MED CTR
SUTTER LAKESIDE HOSPITAL
SUTTER SANTA ROSA
VERDUGO HILLS HOSPITAL

Health Plans with no contact
Aetna Medicare
Gemcare
ON LOK

Medical Groups with no contact
Antelope Valley/Pegasus Medical Group
Bay Valley Medical Group
Centinela Valley IPA
Central Valley Medical Group
Gateway Medical Group, Inc.
Glendale Physicians Alliance
Greater Covina Medical Group
Hill Physicians Medical Group - East Bay
Imperial County Physicians Medical Group
Marin IPA
MidCoast Care Inc
Ojai Valley Community Medical Group
Palo Alto Medical Foundation, PA Division Sutter
Penn Elm Medical Group aka Scripps Clinic MG
Physicians' Healthways IPA
Premier Physician Network
Primary Care Associates Medical Group
PrimeCare - Riverside
San Diego Physicians Medical Group
Santa Clara County IPA
Sante Community Physicians IPA
Scripps Mercy Medical Group
Sharp Community Medical Group - Chula Vista
St. Joseph Heritage Medical Group aka St Jude Affiliated Ph

St. Vincent IPA
Torrance Hospital IPA
UCLA Medical Group
United Family Care
Universal Care Medical Group aka HMO California
Upland Medical Group

Professional Societies with no contact
California Association of Physician Groups

HP
#188
Declined

Jean A. Seago

From: Tamaru, Kurt M [Kurt.Tamaru@wellpoint.com]
Sent: Thursday, January 31, 2008 3:32 PM
To: Jean A. Seago
Cc: Dabbah MD, Zeinab
Subject: Lumetra Peer Review Process Study

Jean,

I would like to thank you for providing the information regarding this voluntary study and respectfully will have to decline participation at this time. While Blue Cross of California is committed to the peer review process and continues to relook at our internal processes, we regret that we could not participate at present.

Sincerely,

Kurt

Kurt M. Tamaru, MD, MBA, FAAFP
Medical Director / Blue Cross of California
Dept of Clinical Quality and Innovations

21555 Oxnard Street, 6J
Woodland Hills, CA 91367
Office Phone: 818-234-4817

Declined

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Site Visit Preferred

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Lumetra Fax Notice

To: Judy Vaccaro	**From**: Dr. Jean Ann Seago
Company: Blue Cross of California	**Phone No.**: 415-677-2160
Fax No.: 818-234-2344	**Date**: 1/9/07
Subject: Phase III Comprehensive Peer Review Study	**Page Count** (Including Cover): 1

Notes: **ATTENTION PEER REVIEW ADMINISTRATOR**

Please be advised that Blue Cross of California has been selected for a site visit for the Medical Board of California Comprehensive Peer Review Study. We will be arranging for an onsite visit during February and need to discuss the document preparation in advance of the visit. Are you the contact person with whom I will be communicating for this part of the project? Thank you.

Jean Ann Seago, PhD, RN
Project Consultant
Comprehensive Study of the Physician & Surgeon Peer Review Process
Lumetra
jseago@lumetra.com
voice 415-677-2160
fax 415-677-2185
www.lumetra.com/mbc
**If you have not already done so, please send a contact email.

Lumetra
One Sansome Street
San Francisco, CA 94104
www.lumetra.com
(415) 677-2000

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
360 Campus Lane, Suite 100
Fairfield, CA 94534
(707) 863-4241

J HP

Declined #151

FACSIMILE TRANSMITTAL

DATE: Friday, October 26, 2007

ATTENTION: Dr. Jean Ann Seago **Number of Pages:** 1

FAX: (415) 677-2195

Dr. Jean Ann Seago,

We received your fax regarding a Comprehensive Peer Review Study and due to current work load we will not be able to participate.

Thank you,

Cynthia McCamey
Executive Assistant to Jack Horn, CEO
Partnership HealthPlan of CA
Phone (707) 863-4241
Fax (707) 863-4340

cmccamey@partnershiphp.org

declined participation

Jean A. Seago

Tricare

139

From: Ekstrand, John R., COL, USA, MC, OASD(HA)/TMA [John.Ekstrand@trow.tma.osd.mil]
Sent: Friday, December 07, 2007 12:01 PM
To: Jean A. Seago
Cc: Grissom, Joyce, Col, OASD(HA)/TMA; Cooper, Carol, CIV, OASD(HA)/TMA; McGuire, Kathryn E. (Kathy), CIV, OASD(HA)/TMA; Large, Kris M., CIV, OASD(HA)/TMA
Subject: TRICARE Senior Prime Peer Review in California

Dr. Seago,

In response to your request for documents related to the peer review process for TRICARE, I would like provide the following outline for our peer review process. As I am sure you are aware, TRICARE is the Federally authorized and funded health plan for the Department of Defense. The TRICARE program is outlined in Chapter 55 of Title 10 United States Code and includes a mandatory Peer Review program as indicated in Section 1079(o) of Title 10 and which has been implemented by Title 32 Code of Federal Regulations Part 199.15 The network development, claims processing and administrative functions including the above peer review program for the plan are contracted to health corporations in three different regions across the US. In the West Region which includes California, TriWest Health Care Alliance is the Managed Care Support Contractor and the contract is overseen by the TRICARE Regional Office - West (TRO-W), located in San Diego.

The peer review process begins with a random sampling of medical charts from across the West Region each month. The charts are reviewed by our National Clinical Quality Monitoring Contractor. Additional cases for peer review may be identified through the grievance process, beneficiary complaints, Congressional inquiries, or by TRIWEST utilization management or case management personnel in the course of medical management processes such as discharge planning. Identified clinical quality findings are referred to TriWest's peer review committee. As Medical Director at the TRO-W, I participate as an observer in those committee meetings.

At the peer review committee level, each case is reviewed through a contracted peer review organization and assigned a severity level. The involved provider is contacted and involved during the assessment process. When a potential finding is confirmed through the committee process, an improvement plan is implemented. Participation in the improvement plan is mandatory to maintain TRICARE certification. The committee utilizes the full range of corrective actions to include education, intensive chart review and reporting the case to state licensure boards as appropriate.

I hope this provides you the necessary information to assure you that TRICARE provides an appropriate peer review process for all health care provided in the State of California. Thank you for your interest in ensuring the highest quality care is provided to all residents of California.

Please feel free to contact me if I can be of further assistance.

COL John R. Ekstrand, MC, MPH, FACP
Medical Director and Chief, Clinical Operations Tricare Regional Office - West
401 West A Street, Suite 2100
San Diego, CA 92101-7908
Phone: (619) 236-5307
FAX: (619) 231-4254

Jean A. Seago Tru Care

From: Grissom, Joyce, Col, OASD(HA)/TMA [Joyce.Grissom@tma.osd.mil]
Sent: Thursday, November 29, 2007 2:41 PM
To: Jean A. Seago
Cc: Ekstrand, John R., COL, USA, MC, OASD(HA)/TMA
Subject: RE: Your fax is on the way. jas

Dear Dr. Seago,

I have asked Col Ekstrand assistance with a short information paper describing the quality oversight processes that involve peer review for network participating providers through TRIWEST as our Managed Care Suppport Contractor in California. This should represent our response to let the California legislature know what peer review takes place for TRICARE beneficiaries residing in California. His contact information is as follows:

COL John Ekstrand, USA, MC
TRICARE Regional Office, West
Medical Director - TRO West
619-236-5307 phone
619-231-4254 fax
john.ekstrand@trow.tma.osd.mil

We will not be able to participate to the extent of providing extensive (for example: 5 yrs of QA minutes)documentation, nor will we provide event level information. If a formal response is required from our OGC reqarding any limits a state may have to require this kind of information from the Department of Defense we will be happy to prepare that as well.

I hope this is of assistance.

Col Joyce Grissom, USAF, MC
Quality Director, TMA
(703) 681-0064; ext 10068

-----Original Message-----
From: Jean A. Seago [mailto:jseago@LUMETRA.COM]
Sent: Thursday, November 29, 2007 2:00 PM
To: Grissom, Joyce, Col, OASD(HA)/TMA
Subject: Your fax is on the way. jas

Jean Ann Seago, PhD, RN
Lumetra
jseago@lumetra.com <mailto:jseago@lumetra.com>
voice 415-677-2160
fax 415-677 2185

destroy all copies of the original message.

Hosp declined

90

Jean A. Seago

From: Honig, Ruth [ruth.honig@ahmchealth.com]
Sent: Tuesday, November 27, 2007 3:39 PM
To: Jean A. Seago
Subject: Peer Review Study

Garfield Medical Center chooses to not participate in this study because the hospital was sold in November of 2004. The records are under two different jurisdictions and are difficult to gather.

Please call me at 626-312-2233 if you have further questions.
Thank you
Ruth

Ruth Honig
Director Clinical Process Improvement
Garfield Medical Center
525 N. Garfield Ave
Monterey Park, Ca 91754
626-312-2233
626-312-2251 (fax)

Monterey Park Hospital
900 S. Atlantic Blvd
Monterey Park, CA 91754
626-570-5731 (fax)

HOSP

Sutter Medical Center of Santa Rosa

A Sutter Health Affiliate

3325 Chanate Road
Santa Rosa, CA 95404
(707) 576 4000

October 8, 2007

Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
One Sansome Street, Suite 800
San Francisco, CA 94104-4448

Re: Lumetra Request Re: "Comprehensive Description of the Peer Review Process in California."

Dear Dr. Seago:

We have received and reviewed the letter dated September 17, 2007, from Pat Daniel, Vice President Medical Review, Lumetra, requesting production of documents to Lumetra in connection with its "Comprehensive Description of the Peer Review Process in California." According to the letter, this project is being conducted on behalf of the Medical Board of California and pursuant to SB 231. The letter further requests production of these documents on or before October 8, 2007.

This letter is to advise you that Sutter Medical Center of Santa Rosa cannot respond to your request within the stated time frame. As you know, the description of many of the documents is vague and ambiguous and we cannot determine precisely which documents to either produce or make available. We will continue to work with the California Healthcare Association ("CHA") and our legal counsel to arrive at a reasonable interpretation and to produce or provide access to a defined set of documents.

We will endeavor to produce what we consider to be responsive documents to Lumetra as soon as reasonably practicable. At this juncture, we anticipate a production of responsive documents within forty-five (45) days of the date of this letter. Please contact us if you would like to discuss this timeframe; otherwise, we will move forward in good faith to arrive at a reasonable interpretation of the list of documents requested.

Thank you for your kind attention.

Sincerely,

Michael J. Cohill
Chief Executive Officer

Did not formally decline but did not respond after several contacts

Jean A. Seago

MG ✓ Delivered #268

From: Steve Beargeon [Steve@keymedical.org]
Sent: Tuesday, October 30, 2007 12:41 PM
To: Jean A. Seago
Subject: RE: Peer Review Study

I will refer this to our legal counsel for response.

From: Jean A. Seago [mailto:jseago@LUMETRA.COM]
Sent: Tuesday, October 30, 2007 12:38 PM
To: Steve Beargeon
Subject: RE: Peer Review Study

Thank you for your email. If the timeline is a problem, please call or email and I can extend the deadline.

For organizations that decline to participate, we have been directed to refer you to two sections in California law;

1) BUSINESS AND PROFESSIONS CODE

SECTION 800-809.9, specifically, 805.2.

http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=00001-01000&file=800-809.9
<http://www.leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=00001-01000&file=800-809.9>

and

2) Senate Bill No. 231

CHAPTER 674

http://info.sen.ca.gov/pub/05-06/bill/sen/sb_0201-0250/sb_231_bill_20051007_chaptered.pdf
<http://info.sen.ca.gov/pub/05-06/bill/sen/sb_0201-0250/sb_231_bill_20051007_chaptered.pdf>

Please let this email serve to advise you that if you are unwilling/unable to provide the requested information, then Lumetra will notify the Medical Board of California. Further action will be determined by the MBC.

If you decline to participate, please email the reason for that decision. Thank you.

Jean A. Seago

From: Steve Beargeon [Steve@keymedical.org]
Sent: Tuesday, October 30, 2007 12:34 PM
To: Jean A. Seago
Subject: Peer Review Study

We respectfully decline to participate in your study.

Steve Beargeon
CEO Key Medical Group

Predeman ✓

St. Francis IPA

MB #249

Jean A. Seago

From: Yvonne Miller [yvonne.miller@applecaremedical.com]
Sent: Tuesday, October 30, 2007 9:36 AM
To: Jean A. Seago
Subject: RE: STUDY PARTICIPATION

Participation would require the expenditure of resources which will not be reimbursed by Lumetra.

Yvonne Miller, R.N.
Vice President of Clinical Services
AppleCare Medical Management, Inc.
AppleCare Medical Group
6131 Orangethorpe Ave., Ste. 280
Buena Park, CA 90620
Phone: (714) 443-4518
Fax: (714) 443-4458

Email: yvonne.miller@applecaremedical.com

From: Jean A. Seago [mailto:jseago@LUMETRA.COM]
Sent: Tuesday, October 30, 2007 9:33 AM
To: Yvonne Miller
Subject: RE: STUDY PARTICIPATION

Can you list your reasons for not participating? thank-jas

Jean Ann Seago, PhD, RN
Lumetra
jseago@lumetra.com
415-677-2160

From: Yvonne Miller [mailto:yvonne.miller@applecaremedical.com]
Sent: Tuesday, October 30, 2007 9:32 AM

Jean A. Seago

From: Yvonne Miller [yvonne.miller@applecaremedical.com]
Sent: Tuesday, October 30, 2007 9:32 AM
To: Jean A. Seago
Cc: Julie Joyce; Surendra Jain M.D.
Subject: STUDY PARTICIPATION

Jean, I found your email address after we hung up. This email is to notify you that we will not be participating in the Comprehensive Peer Review Study.

Yvonne Miller, R.N.
Vice President of Clinical Services
AppleCare Medical Management, Inc.
AppleCare Medical Group
6131 Orangethorpe Ave., Ste. 280
Buena Park, CA 90620
Phone: (714) 443-4518
Fax: (714) 443-4458

Email: yvonne.miller@applecaremedical.com

509 West Weber Ave., Suite 200
Stockton, California 95203
(209) 320-2600 - Fax (209) 320-2644

November 7, 2007

Dr. Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
One Sansome St., Ste. 600
San Francisco, CA 94104-4448

Re: Comprehensive Description Of The Peer Review Process In California

Dear Dr. Seago:

In your letter of September 17, 2007, you advised OMNI IPA (OIPA) that we had been randomly selected to participate in a study of the peer review process in California that is being conducted by Lumetra on behalf of the Medical Board of California. The letter included a list of documents that we would need to submit.

After careful consideration by senior management staff, OIPA respectfully declines to participate in the study. OIPA is a relatively small organization, with limited resources. In the absence of outside financial support, OIPA would not be able to commit the staff and resources necessary to produce the required documents for the study at this time.

We wish you success in this important project, and hope to see the results of the study in the future.

Sincerely,

Sheldon G. Yucht, MD
Medical Director

CC: K. Patel, MD, President and CEO, OIPA
M. Martinez, COO, OIPA

Jean A. Seago

Decline

From: Dena Gehrig [dena.gehrig@BrightMedical.com]
Sent: Friday, November 09, 2007 11:44 AM
To: Jean A. Seago
Subject: Peer Review Study

MC #279

We are unable to participate as we are in the middle of a merger.

Thank you

Dena Gehrig
Administrative Services Manager
Bright Medical Associates
(562) 947-8478 x2905

Jean A. Seago

From: Melissa Carrillo [Mcarrill@sansumclinic.org]
Sent: Thursday, November 08, 2007 11:52 AM
To: MBC Participant
Subject: MBC Study

Decline

We have received a request for information asking us to participate in the MBC study entitled "Comprehensive Description of the Peer Review Process in California". Due to the concerns we have regarding the extreme sensitivity of the information requested, our Board has elected not to participate in the study.

Thank you.

Melissa Carrillo
Risk Management/Provider Relations Manager
Sansum Clinic
PH:(805)681-1743
Fax:(805)681 7710

Dr #249
Sutter
dental
fairfield
Solano
MG

Jean A. Seago

From: Roth, Janie [Rothj3@sutterhealth.org]
Sent: Wednesday, November 14, 2007 2:22 PM
To: Jean A. Seago
Subject: FW: Peer Review Study

Good afternoon Dr. Jean Ann Seago,

We are in receipt of your request to participate in the study entitled, "Comprehensive Description of the Peer Review Process in California. SRMG does not wish to participate in the study"

Thank you,
Janie Roth
Manager, Provider Services/Risk Programs
Sutter Regional Medical Foundation
1234 Empire Street
Fairfield, CA 94533
(707) 434-2049
(707) 434-2073 (fax)
(707) 580-1988 (cell)
rothj3@sutterhealth.org

*** Please note change of email address ***
******

It isn't hard to be good from time to time, whats tough is being good everyday. -Willie Mays

EDWARD A. HINSHAW
TYLER G. DRAA
BARRY C. MARSH
THOMAS E. STILL
BRADFORD J. HINSHAW
JENNIFER STILL
JACQUELINE M. PIERCE
PALLIE B. ZAMBRANO
JENNIFER A. WAGSTER
TASCHA C. HAUT
SCOTT R. KANTER

LAW OFFICES OF
HINSHAW, DRAA, MARSH, STILL & HINSHAW
A PARTNERSHIP
12901 SARATOGA AVENUE
SARATOGA, CALIFORNIA 95070-9998

243 EL DORADO STREET
SUITE 201
MONTEREY, CA 93940
(831) 643-2497

TELEPHONE
(408) 861-6500
FAX
(408) 257-1167
E-MAIL
ehinshaw@hinshaw-law.com

September 28, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street
San Francisco, CA 94104

Re: Comprehensive Peer Review Process – San Jose Medical Group

Dear Dr. Seago:

The San Jose Medical Group has forwarded to me Pat Daniel's letter of September 17, 2007 regarding the above-entitled matter. Please be advised that on behalf of San Jose Medical Group we hereby decline to participate in such a study. The San Jose Medical Group would be willing to reconsider participation if Lumetra would agree to pay for the costs of participating therein.

Should there be any issues you wish to discuss regarding this matter, please feel free to call or do not hesitate to have your legal counsel give me a call.

Yours very truly,

Edward A. Hinshaw

EAH:jwa/*
lseago9-2807.wpd D:9/28/07

cc: Dean Didech, M.D., Chief Medical Officer
San Jose Medical Group

MG

Jean A. Seago

From: [redacted]
Sent: Monday, November 12, 2007 8:40 AM
To: Jean A. Seago
Subject: Peer Review Study

Not discoverable #296

Jean,

I am in receipt of a request for information regarding the Peer Review process. We are not delegated by the health plans for Peer Review. We monitor providers with MBOC accusations and track any complaints we have received internally. We do not have an ongoing Peer Review.

If you have any questions, please contact me.

Thanks

[redacted]

not discoverable

[redacted]

PRIVILEGE AND CONFIDENTIALITY NOTICE

The information in this electronic mail is intended for the named recipient(s) only. It may contain privileged and confidential matter. If you have received this electronic mail in error, please notify the sender immediately by replying to this electronic e-mail or by calling ([redacted] ext. 243. Do not disclose the contents to anyone.

Jean A. Seago

From: [redacted]]
Sent: Tuesday, November 13, 2007 4:21 PM
To: Jean A. Seago
Subject: RE: Lumetra.pdf

No problem. You are correct, our group does not do peer review. Thank you.

-----Original Message-----
From: Jean A. Seago [mailto:jseago@lumetra.com]
Sent: Tuesday, November 13, 2007 1:17 PM
To: Penn, Diane
Subject: RE: Lumetra.pdf

Sorry for the confusion. So, you are saying that your group does not do peer review. Is that correct? jas

Jean Ann Seago, PhD, RN
Lumetra
jseago@lumetra.com
415-677-2160

From: [redacted]
Sent: Tuesday, November 13, 2007 1:04 PM
To: Jean A. Seago
Subject: RE: Lumetra.pdf

Please refer to pages 3 and 5. You are listed as the person to send the requested information related to peer review. We are information you that your request does not apply to our group.

Thank you.

[redacted]

-----Original Message-----
From: Jean A. Seago [mailto:jseago@lumetra.com]
Sent: Tuesday, November 13, 2007 12:56 PM
To: [redacted]
Subject: RE: Lumetra.pdf

[redacted]

November 8, 2007

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Dear Dr. Seago:

I am in receipt of a letter sent to [redacted] at [redacted], San Francisco, CA, 94120, on September 28, 2007. This small, community hospital was delicensed over ten years ago and does not exist. The [redacted] currently operates physician offices and other non-hospital functions at that address. Please update your records of acute care hospitals to show that [redacted] at this address is closed. Thank you.

Sincerely,

[redacted]

Counsel

cc: [redacted]

[redacted]

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Appendix VII: Medical Board of California Documents

- Complaint Information
- Complaint Process: Frequently Asked Questions
- District and Probation Office Locations
- Expert Reviewer Program
- General Office Practices/Protocols: Frequently Asked Questions
- Medical Malpractice Reporting: Frequently Asked Questions
- Physician Credentials/Practice Specialties: Frequently Asked Questions
- Public Information/Disclosure: Frequently Asked Questions
- Complaint Process - Frequently Asked Questions
- Brochure: "How Complaints are Handled"
- Consumer Complaint Form
- Authorization for Release of Medical Information
- Brochure: Information Services for Consumers
- Confidential State Agency Consumer Response Form
- Reporting Requirements for Coroners
- Manual of Model Disciplinary Orders and Disciplinary Guidelines, 9th edition, 2003
- Health Facility/Peer Review Reporting Form
- Peer Review Body Initial Report Form to the Physician Diversion Program Regarding an Investigation of a Mentally or Physically Disabled Physician
- Peer Review Body Final Report Form to the Physician Diversion Program Regarding an Investigation of a Mentally or Physically Disabled Physician
- Report of Settlement, Judgment, or Arbitration Award
- Physician Reporting - Criminal Actions
- Reporting Requirements for Court Clerks
- Health Facility/Peer Review Reporting Form

- The Hot Sheet: A Summary of Administrative Actions: editions from January 2007 to May 2008
- Brochure: “Questions and Answers about Investigations”
- Brochure: “Most Asked Questions about Medical Consultants”
- Notification of Name Change
- Request for Copy of 805 Report
- Outpatient Survey - Patient Death Reporting Form
- Patient Transfer Reporting Form

Complaint Information

The Medical Board is responsible for investigating complaints and disciplining physicians and other allied health professionals who violate the law. If a doctor or other Board licensee appears to have violated the laws that apply to the practice of medicine, Board staff will investigate and charges may be filed.

Central Complaint Unit

California toll-free line: 1-800-633-2322
Phone: (916) 263-2424 / Fax: (916) 263-2435
TDD: (916) 263-0935

- How Complaints are Handled
- Questions and Answers About Investigations
- Most Asked Questions About Medical Consultants
- Frequently Asked Questions

Consumers can contact the Board's Central Complaint Unit for assistance. Staff will assist by providing information about the issues within the Board's authority. Staff will also provide information about how to file a complaint with the Board, and the types of documents that may be needed. Some consumers do not wish to disclose their identity. If that is the case, the Board may be unable to pursue the complaint unless staff can document evidence of the allegations made.

Except for special circumstances, complaints must be in writing. Complaint forms can be obtained by calling the Central Complaint Unit at either of the numbers above or by filling out the following form:

- Consumer Complaint Form — *Fill-In*
- Consumer Complaint Form — Spanish Version
- Instructions on How to Complete a Complaint Form

A complainant may be asked to sign a medical records release form if the Board needs to obtain medical records from a doctor, hospital or other sources to investigate a

complaint. If the complaint is **NOT** within the Board's jurisdiction, staff will provide a referral to the appropriate agency or organization.

Complaints should be mailed to:

Medical Board of California
Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

The Board's staff will review the following types of complaints:

- the quality of care and treatment provided by a physician (e.g., negligence)
- violation of drug laws, misprescribing, or over prescribing
- substance abuse by a physician
- sexual misconduct by a physician
- dishonesty (including filing fraudulent insurance claims)
- practice of medicine by an unlicensed person or persons under the supervision of a physician

In addition to physicians, the staff reviews complaints about:

- registered dispensing opticians (business registration)
- contact lens and/or spectacle lens dispensers
- research psychoanalysts
- licensed midwives

Further, the Board's staff also reviews complaints about licensees in the following professions:

- doctors of podiatric medicine
- physician assistants

However, any disciplinary action taken against one of these licensees is decided by the licensing entity for that profession.

The Board does not regulate health plans or insurance companies. If you need information or have a problem with a **health plan,** contact the **Department of Managed Health Care** at **888-HMO-2219.**

For information about or problems with an **insurance company,** contact the **Department of Insurance** at (213) 897-8921.

This web site contains PDF documents that require the most current version of Adobe Reader to view. To download click on the icon below.

Complaint Process - Frequently Asked Questions

What will happen once I send the Board my complaint?

When the Board receives your complaint, it will be entered into our automated system and assigned a "control number." If your complaint is not within the jurisdiction of the Board, it will be referred to the appropriate agency and you will be notified by mail. If the complaint appears to be within the Board's jurisdiction, an acknowledgment letter will be sent advising you that the Board has received your complaint and that it will be forwarded to an analyst for review. If your complaint concerns the care and treatment you received from a physician, the analyst will request copies of your medical records and a written summary of your care from the physician, with your Authorization for Release of Medical Information. The analyst also may contact any subsequent physician(s) listed on your authorization form. When all of the requested records have been received, you will be notified that your complaint is being sent to a medical consultant for review. The reviews are completed by physicians practicing in the same medical specialty as the physician named in your complaint. For more information on complaints or the consultant review process, please link to our brochures, "How Complaints are Handled"

and "Questions and Answers About Medical Consultants." The analyst handling your complaint will notify you in writing of the findings once the review has been completed.

How long does the whole complaint process take?

There is no specific time frame in which complaints are handled. Once a complaint is received, it will be reviewed by an analyst. The analyst will gather the necessary information to evaluate the complaint. Depending on the complexity of the complaint, it may take several months to review and/or resolve. Refer to our brochure, "How Complaints are Handled" for more information.

Will the doctor know I have filed a complaint?

The "source" of the complaint information (the complainant) is confidential and is not disclosed by the Medical Board. However, if the complaint deals with your care and treatment, the Board's staff will request a copy of your medical records so the physician involved knows that a complaint has been filed regarding your treatment. He/she will not be told who filed the complaint.

I am having difficulty with the care I am receiving right now from my physician. Can the Board assist me?

The Medical Board is responsible for reviewing the care and treatment provided by physicians and will review the concerns you are having. However, the Board cannot intervene or alter a physician's medical care while he/she is providing treatment. You might wish to consult with another physician or, if possible, change doctors.

If I am unhappy with the disposition of the complaint I filed with the Board, what documentation is needed to pursue an appeal?

If you do not agree with the Medical Board's findings, you may request another review by writing a letter describing the specific area(s) of concern and include any additional information you may have such as subsequent physician findings or medical information not previously provided.

What can the Board do for me? What's the purpose in sending a complaint to the Board?

The Medical Board of California is charged with ensuring that physicians are practicing medicine within "the standard of practice in the medical community." The Board's authority is limited to pursuing administrative action against the physician's license to practice medicine (e.g., suspension, revocation, issuing citations for some violations of law and requiring probation or monitoring). The Medical Board cannot assist you in pursuing civil litigation against the physician for "malpractice." The Medical Board cannot share any of the information, records or reports gathered during the course of its review or investigation with the patient or family members.

I have heard that Dr. X is prescribing large amounts of pain medication to people who are addicted to this medication. Will the Board investigate Dr. X?

This concern can be investigated by the Board. However, to investigate a physician's care/treatment, the Board needs information on a patient or patients. The Board can't assess the "quality" of care without focusing on a particular patient, as the Board has no authority to audit or review a physician's medical records without patient consent (or a subpoena which needs to be specific to a patient). If you have any information which you think would be helpful or if you know of any patients who are willing to cooperate with our investigation, please feel free to contact the Board at 800-633-2322 or file a complaint with the Board.

Can I file a complaint without giving my name?

A complaint can be filed anonymously; however, the Board has a difficult time investigating these complaints. If the Board is unable to obtain documentation or evidence of the complaint allegations, the complaint may not be able to be pursued. The Board does accept complaints from individuals who wish to designate themselves as "confidential informants." A "code name" can be used which would allow investigative personnel to discuss the allegations with the "complainant" without disclosing the individual's name. But, again, if medical records are required, the patient's name will have to be disclosed to the physician.

Can I find out whether any complaints have been filed against my physician?

Complaint investigations being conducted by the Medical Board are not public information so this information cannot be disclosed to you. It would become public information at the point that "charges" (or an "Accusation") have been filed. Disciplinary

action documents are available on our Web site by selecting "Enforcement Public Document Search."

Can I file my complaint electronically from the Web site?

Not at this time. Eventually, the Board may be able to offer this service, however, an original signature is still needed on the Authorization for Release of Medical Information.

How long do I have to file my complaint?

Business and Professions Code section 2230.5 states that any **accusation (or formal charges against the physician's license)** filed against a licensee shall be filed within seven years after the act or omission/incident. This means that the Board's investigation must be concluded, the case transmitted to the Attorney General's office **and** the accusation filed by the Attorney General's office before the seven years expires. If a complaint is filed just before the seven-year time limit, the Board may not pursue the case because there won't be enough time to obtain all the documents and have them reviewed before the seven-year statute of limitations expires. There are several exceptions to the statute of limitations including complaints involving sexual misconduct and care and treatment provided to a minor. You may contact the Board for more specific information on the statute of limitations.

Why does the operator insist that I speak to or leave a message with the analyst assigned to my case?

The operators in the Complaint Unit answering calls on the toll-free lines assist hundreds of consumers daily with various inquiries. By connecting you to the staff person assigned to your complaint, the case file will be readily available and the staff person will have the most recent information about the complaint status.

Can the Medical Board help me in filing a lawsuit or malpractice case against the physician?

The Board's authority is limited to pursuing administrative action against the physician's license to practice medicine (e.g., suspension, revocation, issuing citations for some violations of law and requiring probation or monitoring). The Medical Board cannot assist you in pursuing civil litigation against the physician for "malpractice." The Medical Board cannot share any of the information, records or reports gathered during the course

of its review or investigation with the patient or family members, nor can the Board provide referrals to attorneys.

Can the Medical Board provide help in finding a physician who takes MediCare or MediCal?

The Medical Board does not provide physician referrals. You may contact your local medical society in your area for assistance.

As a senior citizen, how can I obtain information for medical services?

The Medical Board of California is not a "medical service" provider. You may wish to look in your local yellow pages under Community Services for Seniors or contact the Department of Aging at 800-510-2020 (in California) or 800-677-1116 (outside California).

As a licensed physician, am I required to report another physician to the Board if I am concerned that the physician may be physically or mentally impaired?

There is no mandatory reporting requirement in the Medical Practice Act to report a colleague for possible impairment. However, as the Board's mission is to provide patient protection, the Board clearly is concerned about physicians who potentially present a danger to their patients. Reporting an impaired colleague to the Medical Board will allow the Board to ensure adequate protections are in place so the public will not be harmed by a colleague who requires assistance. The sources of complaint information are kept confidential by the Board.

District and Probation Office Locations

Cerritos District Office

12750 Center Court Drive South, Suite 750
Cerritos, CA 90703

(562) 402-4668 Phone
(562) 865-5247 Fax

Diamond Bar District Office

1370 South Valley Vista Drive, Suite 240
Diamond Bar, CA 91765-3923

(909) 396-5305 Phone
(909) 396-5313 Fax

Fresno District Office

5070 North Sixth Street, Suite 105
Fresno, CA 93710

(559) 221-0558 Phone
(559) 221-0297 Fax

Glendale District Office

320 Arden Avenue, Suite 250
Glendale, CA 91203

818) 551-2117 Phone
(818) 551-2131 Fax

Pleasant Hill District Office

3478 Buskirk, Suite 217
Pleasant Hill, CA 94523-4326

(925) 937-1900 Phone
(925) 937-1964 Fax

Sacramento District Office

2535 Capitol Oaks Drive, Suite 220
Sacramento, CA 95833

(916) 263-2585 Phone
(916) 263-2591 Fax

San Bernardino District Office

464 West 4th Street, Suite 429
San Bernardino, CA 92401

(909) 383-4755 Phone
(909) 383-4172 Fax

San Diego District Office

4995 Murphy Canyon Road, Suite 203
San Diego, CA 92123

(858) 467-6830 Phone
(858) 467-6836 Fax

San Jose District Office

(408) 437-3680 Phone
(408) 437-3693 Fax

1735 Technology Drive, Suite 800
San Jose, CA 95110-1313

Tustin District Office

(714) 247-2126 Phone
15641 Redhill Avenue, Suite 215 **(714) 247-2137 Fax**
Tustin, CA 92780

Valencia District Office

(661) 295-3397 Phone
27202 Turnberry Lane, Suite 280 **(661) 295-3030 Fax**
Valencia, CA 91355

Probation - North

(916) 263-2125 Phone
2535 Capitol Oaks Drive, #225 **(916) 263-2127 Fax**
Sacramento, CA 95833

Probation - South

(909) 476-7146 Phone
9166 Anaheim Place, #110 **(909) 476-7213 Fax**
Rancho Cucamonga, CA 91730

Probation - L.A. Metro

(562) 402-4668 Phone
12750 Center Court Dr., South #750 **(562) 402-2629 Fax**
Cerritos, CA 90703

Expert Reviewer Program

The Medical Board of California established the Expert Reviewer Program in July 1994 as an impartial and professional means by which to support the investigation and enforcement functions of the Board. Specifically, medical experts assist the Board by providing expert reviews and opinions on Board cases and conducting professional competency exams, physical exams and psychiatric exams.

Requirements for participating in the Board's program are:

1. Possess a current California medical license in good standing; no prior discipline; no Accusation pending; no complaint history within the last three years;
2. Board certification in one of the 24 ABMS specialties (the American Board of Facial Plastic & Reconstructive Surgery, the American Board of Pain Medicine, the American Board of Sleep Medicine and the American Board of Spine Surgery are also recognized) with a minimum of three years of practice in the specialty area after obtaining Board certification;
3. Have an active practice (defined as at least 80 hours a month in direct patient care, clinical activity, or teaching, at least 40 hours of which is in direct patient care) or have been non-active or retired from practice no more than two years.

Participating physicians are reimbursed $150 per hour for conducting case reviews and oral competency exams, $200 an hour for providing expert testimony, and usual and customary fees for physical or psychiatric exams.

If you are interested in providing expert reviewer services to the Medical Board of California, please mail a completed application to the address provided below. Include a current curriculum vitae and a written statement telling the Board why you would like to participate in the program.

Susan Goetzinger, Program Analyst
Expert Reviewer Program
Glendale District Office
320 Arden Avenue, Ste. 250
Glendale, CA 91203
(818) 551-2129
SGoetzinger@mbc.ca.gov

- Expert Reviewer Program Original Application
- Minimum Qualifications to Participate in the Expert Reviewer Program - What the Work Entails

General Office Practices/Protocols - Frequently Asked Questions

Are physicians required to have a chaperone present in the room when examining patients?

No. California law does not require physicians to have a male or female chaperone; however, if having a chaperone or assistant in the exam room makes the patient feel more comfortable and at ease, then the physician should accommodate the patient's request if possible or allow a friend or relative to accompany the patient.

Can a physician refuse me as a patient if I choose not to sign the doctor's Arbitration Agreement?

Yes, the physician can choose to not accept a new patient who does not want to sign the Arbitration Agreement.

Does a physician have to accept new patients?

No. A physician has a right to determine whom to accept as a patient, just as a patient has the right to choose his or her physician. A physician also may terminate a patient without cause as long as the termination is handled appropriately (see California Medical Association guidelines) or for further information visit their Web site at http://www.cmanet.org/ and go to "Terminating Patients".

Does a physician have to write reports and sign documents for disability or Workers' Compensation purposes? Does this have to be done within a specific time frame? Can they charge for this service?

There are no specific laws governing a physician's responsibility in regard to filling out forms for disability insurance or providing reports, etc. Patients should contact their attorney if one is involved, or the disability or Workers' Compensation program, requesting the information as they may have specific rules and/or laws regarding the timely filing of forms/reports. They also may have alternatives that the patient can use if the physician won't cooperate. The Medical Practice Act does not preclude the physician from charging for this service.

Is a physician required to carry malpractice insurance?

No. A physician only is required to carry liability insurance in an outpatient surgery setting pursuant to Business and Professions Code section 2216.2. However, a physician must follow the reporting requirements cited in Business and Professions Code section 802 in regard to lawsuit settlements and arbitration awards. You can find a complete description of the requirements in the Business and Professions Code at the official California Legislative Information Web site, http://www.leginfo.ca.gov/.

Can a physician refuse to treat a current patient?

Yes, but the physician needs to follow appropriate guidelines. See California Medical Association (CMA) guidelines in regard to terminating the doctor/patient relationship. The CMA guidelines indicate a physician must notify the patient in writing informing the patient:

1. the last day the physician will provide care, assuring the patient at least 15 days of emergency treatment and prescriptions before discontinuing service;
2. alternative sources of medical care; i.e., referral to another physician, the patient's insurer/HMO, or the local county's medical society; and
3. information necessary to obtain the patient's medical records compiled during this physician's care.

Does my physician have to provide a "back up" physician when he/she is unavailable; i.e., during vacations or after-hours care?

No. While there is no law mandating a physician provide "back up or cross covering" care when he/she is unavailable, most physicians do have emergency coverage available when they are unavailable, whether it be with another physician or directing the patient to Urgent Care or to a hospital's emergency department.

How long must a physician's office maintain a patient's medical records?

There is no general law requiring a physician to maintain medical records for a specific period of time. However, there are situations or government health plans that require a provider/physician to maintain their records for a certain period of time. Several laws specify a three-year retention period: Welfare and Institutions Code section 14124.1 (which relates to Medi-Cal patients), Health and Safety Code section 1797.98(e) (for services reimbursed by Emergency Medical Services Fund), and Health and Safety Code section 11191 (when a physician prescribes, dispenses or administers a Schedule II controlled substance). The Knox-Keene Act requires that HMO medical records be maintained a minimum of two years to ensure that compliance with the act can be validated by the Department of Corporations. In Workers' Compensation Cases, qualified medical evaluators must maintain medical-legal reports for five years. Health and Safety Code section 123145 indicates that providers who are licensed under section 1205 as a medical clinic shall preserve the records for seven years. However, there is no general statute which relates to all other types of medical records.

How do I obtain a death certificate to find out the name of the physician who signed the form?

You may contact the Department of Vital Statistics at (916) 445-1719 to obtain a copy of a death certificate.

Can I file an anonymous complaint on behalf of a family member/friend against a physician if I believe he/she is overprescribing?

The Board receives and investigates a number of complaints about physician prescribing concerns which are sent by someone other than the patient. These complaints can be difficult to investigate when the patient does not consent to allow the Board to evaluate the care and treatment. It is very helpful in these situations if the Board is provided with as much information as possible about what specific medication is being prescribed and the quantity and frequency. Sometimes this information can be obtained from the pharmacy where the prescriptions are filled. The Board will try to validate the information and in the event that sufficient evidence is available to support a possible violation of the law, an investigational subpoena will be issued for the patient's medical records.

I received a medical evaluation with faulty information which resulted in the cancellation of disability, Workers' Compensation, or other benefits. Can I file a complaint?

The Board has very limited jurisdiction over independent evaluation reports. The role of the evaluator is to provide an "independent opinion" of the individual's condition after 1) examining the patient and/or 2) reviewing the records of the treatment obtained by the other treating physicians involved in the patient's care. The Board will normally recommend that disability patients pursue an appeal through the disability insurance company.

Worker's compensation independent (IME) and qualified medical examiner (QME) evaluations are governed by the Medical Unit of the Division of Workers' Compensation. This state agency is responsible for regulating the conduct of IMEs and QMEs in workers' compensation cases, and may be able to advise you on other workers' compensation-related issues. You may contact them at P.O. Box 8888, San Francisco, CA 94128-8888.

Can the Medical Board help in finding a physician for Medi-Cal, Medicare, a specialist or a IME/QME?

No, the Board does not provide referrals to physicians. You can contact your local medical association for referrals in various medical specialties or your individual

insurance plan or HMO. To locate the medical association/society in your area you can log onto the California Medical Association's Web site at http:/www.cmanet.org/PUBLICDOC.cfm?docid=63.

Can a physician treat and prescribe to family, friends or employees?

There is no law which specifically prohibits a physician from evaluating, diagnosing, treating, or prescribing controlled substances to a family member, employee or friend. However, the practice is discouraged. There are laws to consider when assessing any prescribing issues which include: 1) a physician cannot prescribe without a "good faith" exam and 2) a medical record must be created which documents the medical need for the prescription. Basically, a physician must follow the same practice/protocol for any patient in which medications are prescribed.

Can a physician have a personal relationship with a patient?

Business and Professions Code section 726 states that sexual abuse, misconduct or relations with a patient are considered unprofessional conduct and grounds for disciplinary action. The Board considers any type of personal relationship between the doctor and the patient to be a very serious breach of public trust and investigates these complaints. Please refer to "Questions and Answers about Investigations" which provides general information about complaint investigations.

What if a personal relationship developed between the physician and the patient and it was consensual?

The fact that the personal relationship between the physician and the patient at some point was consensual does not negate the fact that the physician breached professional ethics and boundaries, and possibly broke the law, by initiating a personal relationship with a patient. Filing a complaint with the Board would be strongly encouraged so the issue could be investigated in the event that other complaints with similar allegations had been reported.

My teenage child was seen by the physician and the physician refuses to disclose the reason for the visit. Can I withhold payment of the bill unless the physician answers my questions or provides me with the medical record from the visit?

No. Children from the age of 12-17 have the authority to "consent" to some types of treatment without the permission of their parent or guardian. The physician is obligated to maintain the doctor/patient confidentiality, particularly when the physician feels that the disclosure of the information will have a negative impact on the relationship with the patient. HIPAA also prevents the disclosure of doctor/patient information to the parent.

What is required by the Medical Board to open a medical clinic?

The medical clinic must be wholly owned and controlled by a physician or physicians (a layperson cannot own a clinic). See Business and Professions Code sections 2400 - 2417 and Corporations Code sections 13400 - 13410 for the requirements on what business structures can be used (sole ownerships, professional partnerships, and professional corporations). If the physician/owner is practicing under a name other than his/her own name (i.e., a clinic name, like "Sun Valley Medical Clinic"), the physician must obtain a Fictitious Name Permit (FNP) from the Medical Board. This is separate from any fictitious business name filings required by city or county governments. Applications for the Medical Board's FNP can be obtained either on the Board's Web site or from the Division of Licensing by calling (916) 263-2382 (press option 1). If a physician who owns a clinic is a Medicare provider, he or she can obtain certification for the clinic through the Department of Health Services without having to apply for an FNP.

How do I obtain copies of my lab results?

Health and Safety Code section 123148 requires the health care professional who requested the test be performed to provide a copy of the results to the patient, if requested either orally or in writing. When the patient requests his/her lab results, the health care provider should provide the results to the patient within a "reasonable" time period after the results are received by the provider. Depending on the results of the tests, some physicians may want the patient to schedule an appointment to review and discuss the results and any follow-up testing or treatment that might be required. The test results cannot be released by the lab performing the test and must be released by the provider requesting the test(s).

Medical Malpractice Reporting - Frequently Asked Questions

The laws that govern mandatory malpractice reporting to the Medical Board of California (MBC) are found in California Business & Professions Code Sections 801.01 and apply to professional liability insurers, self-insured governmental agencies, physicians and/or their attorneys, and employers. Click here to access these laws.

Reporting Requirements:

- Does a physician have to be named on a report if the settlement is on behalf of the corporation/group, etc.?

Yes.

- What if the malpractice claim was filed strictly due to a "system" problem and did not pertain to any care and treatment by a physician?

If the malpractice action strictly involved a "system" problem, a report need not be filed with the MBC.

- What if the care involved a non-physician provider?

A report need not be filed with the MBC but there may be reporting requirements to other professional licensing boards or bureaus.

- Is a report to the Medical Board required if a settlement, judgment or arbitration award (or a specified portion thereof) is attibuted to an individual who was an unlicensed resident at the time of the incident?

No. Reporting is intended to alert the Medical Board to situations where a licensed practitioner may be negligent or incompetent in his or her professional practice. Residents, interns, and medical students have not established that they possess the minimum entry level competence. The purpose of the statute requiring reporting is not

served by requiring a report where the incident occurred before the practitioner became licensed.

Settlement Apportionment:

- How does a reporting entity apportion a specific amount to individual physicians if the settlement is paid on behalf of the corporation/group, etc.?

Unless the settlement/judgment/arbitration award specifically apportions an amount to each particular physician named in the claim or action, the Medical Board will attribute the full amount of the award to each physician named.

- If a report of a settlement over $30,000 is submitted but the amount apportioned to each physician is under $30,000, will the report be counted as a settlement against the individual physician as part of the accumulated totals which may result in public disclosure?

No.

- If a report of a settlement over $30,000 is submitted on behalf of a corporation, group, etc., but no amount is apportioned to the physician named, will the report be counted as a settlement against the individual physician as part of the accumulated totals which may result in public disclosure?

A report need not be filed with the MBC but there may be reporting requirements to other professional licensing boards or bureaus.

- Is a report to the Medical Board required if a settlement, judgment or arbitration award (or a specified portion thereof) is attibuted to an individual who was an unlicensed resident at the time of the incident?

Yes. If no amount is shown as Paid on Behalf of the Physician, the Board will attribute the entire amount of the settlement to the named physician.

Medical Board Processing:

- What happens when a report is filed with the Medical Board of California?

Medical Board staff in the Central Complaint Unit review all information provided to determine whether a violation of the Medical Practice Act occurred. Each named physician is given an opportunity to respond.

Public Disclosure:

- When does information get posted to the Board's Web site?

Judgments and arbitration awards are posted upon receipt. Settlements resolved after 1-1-03 are disclosed after a physician has accumulated three or four settlements within a 10-year period (depending upon the specialty of the physician).

- What should a physician do if he or she disagrees with the information posted on the Medical Board Web site?

Physicians should contact the entity who reported the information to the Medical Board.

Physician Credentials/Practice Specialties - Frequently Asked Questions

How do I find out if my doctor has a practice specialty?

For information concerning a physician's specialty, please contact the American Board of Medical Specialties at 866-275-2267.

My physician told me that she was board certified and handed me a card with her board specialty. Is it mandatory for my physician to be "board certified" in her specialty?

There is no current law that requires that a physician be "board certified." However, unless physicians are certified by a specialty board as defined by law, physicians are prohibited from using the term "board certified" in their advertisements. The law does not, however, prohibit the advertising of specialization regardless of board certification status, nor does it prohibit the use of "diplomate, member, approved by," or any other term that is subject to interpretation by prospective patients.

My physician informed me that he is board certified by "XYZ" specialty board and is advertising in the local newspaper. Is this legal?

Business and Professions Code §651(h)(5)(A) & (B) prohibits physicians from advertising that they are board certified unless they are certified by one of the following: a member board of the American Board of Medical Specialties, a specialty board with the Accreditation Council for Graduate Medical Education accredited postgraduate training

program, or a specialty board approved by the Medical Board of California's Division of Licensing as equivalent. For more information on specialty boards approved by the Board, go to http://www.medbd.ca.gov/specialty.html.

How do I know if my physician is board certified or if he or she is certified by an approved specialty board?

You may contact the American Board of Medical Specialties (ABMS) at 866-275-2267. In addition, the Medical Board has approved the following specialty boards: American Board of Facial and Plastic Reconstructive Surgery; American Board of Pain Medicine; American Board of Sleep Medicine; and the American Board of Spine Surgery. Links to the above-named boards are available through our Web site at: http://www.medbd.ca.gov/specialty.html.

How do I find out if my doctor is licensed or a "real" medical doctor?

You may obtain information about a physician from the Medical Board of California by calling (916) 263-2382, option #1, or by going to "Check Your Doctor Online" and viewing a physician's profile. You also may want to check the Osteopathic Medical Board's Web site if you are unable to locate your physician on our Web site.

Has my doctor ever been in any kind of "trouble" or had any complaints filed against him?

You may check your doctor's profile on our Web site at "Check Your Doctor Online." Complaints are confidential in California. However, disciplinary action against a licensee is public.

How do I find out if my doctor has been, or is, licensed in another state?

You may contact the Federation of State Medical Boards located in Euless, TX, at the toll-free number 866-275-2267 for further information about other state medical boards.

Public Information/Disclosure Frequently Asked Questions

Can you tell me if this doctor has any complaints?

No. Complaints are not public information since they are just allegations; if a complaint results in discipline, that action is public. To determine if a physician has been disciplined, click here.

What is a public reprimand?

A public reprimand is a lesser form of discipline that can be negotiated for minor violations before the filing of formal charges (i.e., an accusation). The physician is "disciplined" in the form of a public letter of reprimand.

What does "probation completed" mean?

This means that the Board took administrative action against a physician and required that he/she fulfill some terms and conditions (or monitoring) for a period of time. The notation "probation completed" means the physician completed the terms and conditions and has been released from the probation. You may obtain the documents describing the action taken against the physician from our Central File Room. The documents outline all of the terms and conditions that the Board imposed on the licensee and describe the reasons for that action. The Central File Room can be reached at (916) 263-2525.

What is the section of law or code that identifies what information about a physician the Board is required to disclose to the public?

Sections 803.1 and 2027 of the Business & Professions Code identify what information the Board is authorized to disclose to the public. If you would like to review these sections of law, they are available through the Internet at the following Web site: http://www.leginfo.ca.gov/calaw.html

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What constitutes a citation and who issues citations and fines?

The Citation and Fine Program is an alternative method by which the Medical Board can impose a sanction and take an administrative action against a licensed or unlicensed individual found in violation of a law or regulation governing the practice of medicine. The Board's chief of enforcement and the chief of the Division of Licensing have authority to issue citations and fines to physicians and allied health licensees for specified violations of law. Citations are not discipline, although they constitute a public record of the action taken. A copy of the citation is a public record and is posted on the Web site, and must be provided to the public for five years from the date of resolution.

Is public information available on the Web site regarding medical malpractice judgments and arbitration awards filed against a physician?

When you search for a physician through "Check Your Doctor Online," the physician's "profile" will show medical malpractice judgments and arbitration awards of any amount reported to the Board since 1993. However, malpractice cases that result in settlement are not reflected unless specific criteria are met (see Enforcement Public Document Search). You also can check with the county courthouse to research whether civil lawsuits for medical malpractice have been filed against a doctor.

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I am having difficulty with the care I am receiving right now from my physician. Can the Board assist me?

The Medical Board is responsible for reviewing the care and treatment provided by physicians and will review the concerns you are having. However, the Board cannot intervene or alter a physician's medical care while he/she is providing treatment. You might wish to consult with another physician or, if possible, change doctors.

If I am unhappy with the disposition of the complaint I filed with the Board, what documentation is needed to pursue an appeal?

If you do not agree with the Medical Board's findings, you may request another review by writing a letter describing the specific area(s) of concern and include any additional information you may have such as subsequent physician findings or medical information not previously provided.

What can the Board do for me? What's the purpose in sending a complaint to the Board?

The Medical Board of California is charged with ensuring that physicians are practicing medicine within "the standard of practice in the medical community." The Board's authority is limited to pursuing administrative action against the physician's license to practice medicine (e.g., suspension, revocation, issuing citations for some violations of law and requiring probation or monitoring). The Medical Board cannot assist you in pursuing civil litigation against the physician for "malpractice." The Medical Board cannot share any of the information, records or reports gathered during the course of its review or investigation with the patient or family members.

I have heard that Dr. X is prescribing large amounts of pain medication to people who are addicted to this medication. Will the Board investigate Dr. X?

This concern can be investigated by the Board. However, to investigate a physician's care/treatment, the Board needs information on a patient or patients. The Board can't assess the "quality" of care without focusing on a particular patient, as the Board has no authority to audit or review a physician's medical records without patient consent (or a subpoena which needs to be specific to a patient). If you have any information which you think would be helpful or if you know of any patients who are willing to cooperate with our investigation, please feel free to contact the Board at 800-633-2322 or file a complaint with the Board.

Can I file a complaint without giving my name?

A complaint can be filed anonymously; however, the Board has a difficult time investigating these complaints. If the Board is unable to obtain documentation or evidence of the complaint allegations, the complaint may not be able to be pursued. The Board does accept complaints from individuals who wish to designate themselves as "confidential informants." A "code name" can be used which would allow investigative personnel to discuss the allegations with the "complainant" without disclosing the individual's name. But, again, if medical records are required, the patient's name will have to be disclosed to the physician.

Can I find out whether any complaints have been filed against my physician?

Complaint investigations being conducted by the Medical Board are not public information so this information cannot be disclosed to you. It would become public information at the point that "charges" (or an "Accusation") have been filed. Disciplinary

action documents are available on our Web site by selecting "Enforcement Public Document Search."

Can I file my complaint electronically from the Web site?

Not at this time. Eventually, the Board may be able to offer this service, however, an original signature is still needed on the Authorization for Release of Medical Information.

How long do I have to file my complaint?

Business and Professions Code section 2230.5 states that any **accusation (or formal charges against the physician's license)** filed against a licensee shall be filed within seven years after the act or omission/incident. This means that the Board's investigation must be concluded, the case transmitted to the Attorney General's office **and** the accusation filed by the Attorney General's office before the seven years expires. If a complaint is filed just before the seven-year time limit, the Board may not pursue the case because there won't be enough time to obtain all the documents and have them reviewed before the seven-year statute of limitations expires. There are several exceptions to the statute of limitations including complaints involving sexual misconduct and care and treatment provided to a minor. You may contact the Board for more specific information on the statute of limitations.

Why does the operator insist that I speak to or leave a message with the analyst assigned to my case?

The operators in the Complaint Unit answering calls on the toll-free lines assist hundreds of consumers daily with various inquiries. By connecting you to the staff person assigned to your complaint, the case file will be readily available and the staff person will have the most recent information about the complaint status.

Can the Medical Board help me in filing a lawsuit or malpractice case against the physician?

The Board's authority is limited to pursuing administrative action against the physician's license to practice medicine (e.g., suspension, revocation, issuing citations for some violations of law and requiring probation or monitoring). The Medical Board cannot assist you in pursuing civil litigation against the physician for "malpractice." The Medical Board cannot share any of the information, records or reports gathered during the course

of its review or investigation with the patient or family members, nor can the Board provide referrals to attorneys.

Can the Medical Board provide help in finding a physician who takes MediCare or MediCal?

The Medical Board does not provide physician referrals. You may contact your local medical society in your area for assistance.

As a senior citizen, how can I obtain information for medical services?

The Medical Board of California is not a "medical service" provider. You may wish to look in your local yellow pages under Community Services for Seniors or contact the Department of Aging at 800-510-2020 (in California) or 800-677-1116 (outside California).

As a licensed physician, am I required to report another physician to the Board if I am concerned that the physician may be physically or mentally impaired?

There is no mandatory reporting requirement in the Medical Practice Act to report a colleague for possible impairment. However, as the Board's mission is to provide patient protection, the Board clearly is concerned about physicians who potentially present a danger to their patients. Reporting an impaired colleague to the Medical Board will allow the Board to ensure adequate protections are in place so the public will not be harmed by a colleague who requires assistance. The sources of complaint information are kept confidential by the Board.

OVERVIEW OF THE COMPLAINT REVIEW PROCESS

The Medical Board of California has authority over licensed medical doctors (MDs) in California and has the authority to enforce the provisions of the Medical Practice Act (within the California Business & Professions Code). The Board also handles complaints against certain affiliated healing arts professionals: podiatrists, physician assistants, registered dispensing opticians, research psychoanalysts and midwives.

Your complaint will be assigned to a Consumer Services Analyst for review. The analyst will gather the information necessary to evaluate your complaint. The initial review of your complaint will be undertaken immediately, however, depending on the complexity of the case, may take several months to resolve.

Below are the most common types of complaint issues filed with the Board as well as an outline of the normal review process.

■ Quality of Care Complaints

When you file a complaint involving medical care and treatment, the Medical Board will obtain copies of all your medical records pertaining to that treatment. If you have not completed the "Authorization for Release of Medical Records" on the back of the Consumer Complaint Form, the analyst handling your complaint will send you one to complete and sign. The release form must be completed and signed to avoid a delay in processing your complaint.

When a completed release form is received, the analyst will request the needed records, as well as a written summary of the care from each of the treating medical providers. Once all records and summaries are received, the entire file will be forwarded to one of the Board's medical consultants for a thorough review. You will be notified by letter when this occurs.

The medical consultant's evaluation will determine whether the complaint requires further review by one of the Board's investigative offices, or whether the Central Complaint Unit will close the complaint.

If the review determines that the actions of the doctor were not below the acceptable standard of medical care, the Board has no authority to proceed, and the complaint will be closed. If the Board finds that the treatment fell below the standard of care but does not represent gross negligence, the complaint will be closed but will be maintained on file for the Board's future reference. If a complaint is referred to an investigative office and a violation is confirmed, the case may be submitted to the Office of the Attorney General for a formal charge that may lead to disciplinary action against the doctor's license.

The Board cannot review matters that occurred more than seven years ago (with some limited exceptions) or 10 years ago on complaints alleging sexual misconduct.

■ Failure to Provide Medical Records

If a medical provider fails to release a copy of your medical records to you upon your written request, he or she may be in violation of Health and Safety Code Section 123110. If you have difficulty obtaining a copy of your records, please call us as we may be able to assist you in obtaining your records.

■ High Priority Complaints

Complaints alleging negligence that involve patient death or serious bodily injury are given the highest priority. Complaints alleging sexual misconduct, excessive prescribing, unlicensed practice of medicine or a physician's substance abuse will usually be forwarded to one of our district offices for investigation. However, if the complaint allegations are not clear, you may be contacted for further information before determining whether an immediate field investigation is warranted.

■ Injury, Disability, Fitness for Duty Evaluations

Medical providers often conduct evaluations to determine an individual's medical condition related to an injury, disability, or fitness for duty. The Medical Board has limited jurisdiction in this area as no "care and treatment" is provided. If you are dissatisfied with the results of your evaluation, appeal processes may be available through the agency or individual who requested the evaluation. It is recommended that the appeal options be pursued.

The Medical Board has no authority over the following:

- **Chiropractors** *(contact Board of Chiropractic Examiners)*
- **Dentists** *(contact Board of Dental Examiners)*
- **Ethical/Office Issues** *(contact local medical society)*
  Ethical issues include "bedside manner," (attitude, demeanor) and office staff.
- **Health Maintenance Organizations (HMOs)** *(contact Department of Managed Health Care)*
- **Hospitals** *(contact Dept. of Health Services)*
- **Insurance Companies** *(contact Department of Insurance)*
- **Malpractice actions/civil lawsuits**
  If you are seeking damages and restitution only, you need to seek legal advice. The Medical Board cannot share information or assist with lawsuits.
- **Medi-Cal** *(contact Department of Health Services or Department of Justice, Medi-Cal Fraud)*
- **Medicare** *(contact the federal centers for Medicare and Medicaid)*
- **Nurses** *(contact the Board of Registered Nursing or the Board of Vocational Nurse and Psychiatric Technicians)*
- **Optometrists** *(contact Board of Optometry)*
- **Osteopathic Physicians (DOs)** *(contact Osteopathic Medical Board of California)*
- **Prices Charged** *(contact medical society for medical services actually provided to the patient)*

The Medical Board also has no authority to obtain a refund from a medical provider ***unless*** *there is a double payment by the insurance company.*

MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

- **To discuss your complaint, call:**

1-800-633-2322
or 916-263-2424
Fax: (916) 263-2435
TDD: (916) 263-0935

- **To check on a specific doctor, call our Consumer Information Unit:**

916-263-2382

- **Visit our Web site:**

www.medbd.ca.gov

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

3/03

How Complaints Are Handled

Central Complaint Unit

Medical Board of California
the state agency that licenses medical doctors, investigates complaints, and disciplines those who violate the law

MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, California 95815
1-800-633-2322
(916) 263-2424 – Fax (916) 263-2435

CONSUMER COMPLAINT FORM

Instructions for Filing Your Complaint

- ✓ Fill in the full name and address, telephone number, license number (if known) of the person your complaint is against. Also write this information in the first section of the Authorization for Release of Medical Records on the reverse side of the Complaint Detail Form.
- ✓ If the patient has seen another doctor for the **same** problem, include the name, address and date(s) of treatment on the release section of the complaint form.
- ✓ Write your complaint and include as many specific details as possible (who, what, when, where, why). Include the date(s) of treatment and specific examples of the problems with the care and treatment and use extra sheets of paper, if needed. Send us copies of any documents in support of your complaint which may include patient records, photographs, audiotapes, correspondence, billing statements, proof of payments, etc.
- ✓ Sign and date the complaint form at the bottom of the page and on the Authorization Release Form.

Authorization for Release of Medical Information

The Authorization for Release of Medical Information found on the reverse side of the Complaint Details form is a legal authorization for the Medical Board's staff to obtain information about the patient's care from the doctors and/or medical facilities involved in the medical care. **ANY EXTRA COMMENTS, NOTATIONS, ETC. MAKE THE FORM VOID AND WE WILL HAVE TO ASK YOU TO COMPLETE ANOTHER RELEASE FORM.** If you wish to provide us with additional information, please do so using a separate sheet of paper. If there are more than four physicians or medical facilities, you may copy the blank form in order to have enough spaces. When this form is completed and signed, it allows the Medical Board to order records from **ONLY** the doctors or facilities you have listed on the medical record release form.

Print or **type** the patient's name, date of birth, date of death, and medical record number if applicable. If we need to contact you to clarify your information, it will delay the review process. FILL IN THE FULL NAME AND ADDRESS OF THE PERSON YOU ARE COMPLAINING ABOUT IN THE FIRST SECTION. Fill in the names and addresses of all other health care providers where the patient was seen for the medical problems **in this specific complaint** (doctors and/or clinics or hospitals, etc.) using the other sections on the medical release.

NOTE: The release form must be signed and dated **by either the patient or the individual legally authorized to make medical decisions for the patient.** If the patient is unable to sign the release, the form may be signed by: 1) the next of kin, if the patient is deceased (provide a copy of the Death Certificate); 2) the parent of a minor child; or 3) the person named by the patient in a signed Power of Attorney granting the person authority to make **medical decisions** for the patient (provide a copy of this document).

MEDICAL BOARD OF CALIFORNIA
CONSUMER COMPLAINT FORM

PERSON REGISTERING THE COMPLAINT

Please Print or Type

☐ Mr. ☐ Ms.

Name: _____
(Last Name) (First Name) (M.I.)

Mailing Address: _____

_____
(City) (State) (Zip)

Phone Number: _____
(Daytime Number) (Evening Number) (Cell phone/E-mail address)

☐ Mr. ☐ Ms.

Patient Name: _____
(Last Name) (First Name) (M.I.)

Patient Date of Birth: _____ **Your Relationship to Patient:** _____

NATURE OF COMPLAINT

Please check the box which best describes the nature of your complaint and provide details on the next page

☐ **Substandard Care** (e.g., Misdiagnosis, Negligent Treatment, Delay in Treatment, etc.)

☐ **Prescribing Issues** (e.g., excessive/under prescribing, Internet)

☐ **Unlicensed Provider orAiding/Abetting unlicensed practice**

☐ **Sexual Misconduct**

☐ **Physician/Provider Impairment** (e.g., Drug, Alcohol, Mental, Physical)

☐ **Unprofessional Conduct** (e.g., Breach of Confidence, Record Alteration, Fraud, Misleading Advertising, Arrest or conviction)

☐ **Office Practice** (e.g., Failure to Provide Medical Records to Patient, Failure to Sign Death Certificate, Patient Abandonment)

Other _____

Notice: The information included on the complaint form is requested per Section 2220 of the Business and Professions Code. Except for the name of the physician, all information requested is voluntary, but failure to provide the requested information may delay or prevent the investigation of your complaint. Provide as much information as possible in connection with the complaint. The information on the complaint form will be used in part to determine whether a violation of State Law has occurred. If a violation is substantiated, the information may be transmitted to other government agencies, including the Attorney General's Office.

I wish to complain about the individual named below. I understand that the Medical Board does not assist citizens seeking return of their money or other personal remedies. I am, however, submitting this information so that it may be determined whether disciplinary action against this practitioner's license should be considered.

Check one:

☐ **Physician (M.D.)** ☐ **Podiatrist (DPM)** ☐ **Physician Assistant (PA)** ☐ **Registered Dispensing Optician (RDO)** ☐ **Midwife** ☐ **Unlicensed Provider**

COMPLAINT REGISTERED AGAINST **Please Print or Type**

Name: _____
(Last Name) (First Name) (M.I.)

Office/Facility Name: _____ **License No.** (If known): _____

Street Address: _____
(Address) (City) (State) (Zip Code)

Phone Number: ( ) _____

Has the patient been examined/treated by another professional for this same condition?

☐ **No** ☐ **Yes** **If yes, provide name and address on the Authorization for Release of Medical Information**

Reason for Treatment: _____

Date(s) of Treatment: _____

DETAILS OF COMPLAINT

(Attach additional sheets if necessary)

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
2005 Evergreen Street, Suite 1200, Sacramento, CA 95815

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name	Date of Birth
Medical Record Number (If applicable)	Date of Death (If applicable)
Control Number	Social Security No. (Optional)

I, the undersigned hereby authorize:

Physician/Facility_____

Address_____

City/State/Zip Code_____

Phone Number(s)_____

Treatment Date(s)_____

to disclose medical records in the course of my diagnosis and treatment to the **Medical Board of California, Enforcement Program,** a healthcare oversight agency. This disclosure of records authorized herein is required for official use, including investigation and possible administrative proceedings regarding any violations of the laws of the State of California. This authorization shall remain valid for three years from the date of signature. **A copy of this authorization shall be as valid as the original.** I understand that I have a right to receive a copy of this authorization if requested by me. I understand that I have the right to revoke this authorization by sending written notification to the Medical Board of California at the above address. My written revocation will be effective upon receipt by the Medical Board of California but will not be effective to the extent that such persons have acted in reliance upon this Authorization. I understand that the recipient of my information is not a health plan or health care provider and the released information may no longer be protected by federal privacy regulations.

Patient Signature_____ Date_____
or Legal Representative_____ Date_____
Relationship

NOTE: Failure by a physician, podiatrist or health care provider to provide the requested records within 15 days, or a health care facility in 30 days, of receipt of this request and authorization may constitute a violation of Section 2225.5 of the Medical Practice Act and may result in further action by the Board. This release is compliant with the requirements of HIPAA and Civil Code Section 56.11.

What is the Medical Board of California?

The Medical Board of California (Board) is a state government agency which licenses and disciplines medical doctors. The 21-member Board is appointed by the Governor (12 physicians and 7 public members), the Speaker of the Assembly (1 public member), and the Senate Rules Committee (1 public member). The Board's Division of Licensing assures that all physicians licensed by the Board meet minimum requirements established by law for education and training. The Board's Division of Medical Quality provides two types of consumer services:

- Investigation of complaints against physicians
- Information about physicians

The Board is not a physician-referral service. If you want a physician referral, you may wish to contact your local medical society.

Common Causes for Filing Disciplinary Action Against a Physician

A physician can be disciplined for a number of reasons. Three of the most common violations are:

1. Gross Negligence
Gross negligence is an *extreme departure* from accepted standards of medical practice.

Gross negligence may include:

- Not performing basic diagnostic tests
- Not recognizing or acting on common symptoms presented by a patient
- Not using accepted, effective treatments or diagnostic procedures
- Not referring a patient to a specialist when appropriate

2. Repeated Negligent Acts
Negligent acts that are not an *extreme* departure from accepted standards of practice are still considered a departure from care and considered *simple negligence*. One act of simple negligence is not enough to take formal action against a doctor's license; however, *repeated* negligent acts may be sufficient grounds.

3. Incompetence
If a physician is found to be lacking in knowledge and performing procedures that are beyond his or her training or expertise, or continuing to use a procedure that is unnecessary or obsolete, this may be evidence of incompetence. In addition, a physician who is unable to recognize and act appropriately on a patient's history and symptoms would be considered incompetent.

Other Causes for Filing Disciplinary Action

- Sexual misconduct
- Conviction of a serious crime
- Substance abuse
- Violating drug laws or unlawful prescribing
- Dishonesty, including filing false or fraudulent insurance, Medi-Cal or Medicare claims, making illegal referrals, or engaging in kickback schemes
- Knowingly allowing an unlicensed person to practice medicine

When Should You File a Complaint with the Board?

You should consider filing a complaint with the Medical Board when you believe what a physician has done, is doing, or not doing has harmed or may cause harm to you or another person. If you are not sure about a situation, you should call to ask for guidance. The Medical Board's toll-free consumer complaint line is: **(800) 633-2322.**

If you file a complaint with the Board, it is confidential (however, the physician is advised) unless the Board holds a hearing on the case. If that happens, you may be asked to testify or to make a statement under oath about the circumstances relating to the complaint.

The Complaint and Disciplinary Process

Board staff receive and evaluate complaints against physicians. Complaints are investigated where there is reason to believe the law may have been violated. The Attorney General's (AG) office files charges against violators and prosecutes the charges. A Deputy AG represents the Board at public hearings held by Administrative Law Judges (ALJ) for physicians accused of violating the law. Members of the Board's Division of Medical Quality may: 1) adopt, modify, or reject the proposed decisions of the ALJ following hearings; 2) adopt alternative decisions when ALJ decisions are rejected; and 3) adopt disciplinary actions that are negotiated through *stipulated agreements* instead of going to hearing.

If the charges are proved at hearing, the Board's final decisions can: 1) revoke or suspend the physician's license to practice medicine, 2) place the physician on probation, 3) restrict his or her practice, or 4) impose other legal penalties.

In certain situations, Board staff may request a competency examination or a psychiatric examination of the physician.

The Board staff may refer a case against a physician to local law enforcement when it determines criminal violations may have occurred.

Diversion Program

The Board oversees a Diversion Program that monitors the rehabilitation of physicians and other healthcare professionals impaired by alcohol, substance abuse, or mental illness. In some disciplinary decisions, participation by the physician in the Diversion Program may be a requirement by the Board.

Obtaining Information about Physicians from the Board

- Is the physician currently licensed? Check a physician's profile online at: www.caldocinfo.ca.gov, or call the consumer information line at (916) 263-2382 to learn if your physician is licensed.
- Has the Board ever taken disciplinary action against the physician? If yes, ask how you can request a copy of the disciplinary decision.
- Is a disciplinary charge (called an *Accusation*) pending? If yes, ask how you can request a copy.
- Is there any other public information on this physician's record (for example, criminal convictions, malpractice judgments)?

If You Have a Problem with a Physician . . .

Most patients have no major problems with their physicians. If problems exist, they usually are minor and can be resolved through discussion with your physician. The Board has no authority to act on complaints such as scheduling, personality conflicts, or disputes over bills or insurance. If you have a problem with a physician and you believe it is affecting the quality of care you receive, you should contact the Medical Board.

Be informed. Be healthy.

- Always use an appropriately licensed healthcare professional
- Don't accept treatment from or take prescription drugs from unlicensed individuals
- Use the Medical Board as a physician information resource

In addition to physicians, the Medical Board of California also accepts complaints against:

- Opticians and Contact Lens and Spectacle Lens Dispensers
- Medical Assistants
- Podiatrists
- Physician Assistants
- Research Psychoanalysts
- Licensed Midwives (non-nurse)

To talk to a Medical Board staff person who can assist you with your complaint or refer you to the proper agency, call the Board's toll-free complaint line:

(800) 633-2322
(consumer complaint line)

Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236

(916) 263-2382
(ask about a physician)

You can access much of this information from the Medical Board's Web site at:

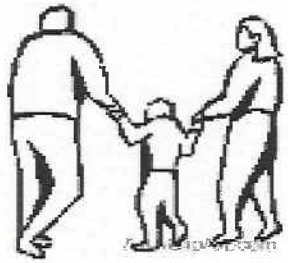
www.mbc.ca.gov/

(Rev. 7/04)

Medical Board of California

Information and Services for Consumers

Be informed. Be healthy.



www.mbc.ca.gov/

(800) 633-2322
(consumer complaint line)
(916) 263-2382
(ask about a physician)

STATE OF CALIFORNIA
State and Consumer Services Agency
Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
Executive Office
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
phone: (916) 263-2389; fax: (916)-263-2387

CONFIDENTIAL STATE AGENCY CONSUMER RESPONSE FORM

Print and mail (or fax) completed form to above address.

This form is intended for use to comment, make suggestions or to complain about the performance of the **Medical Board of California.** To submit a complaint about a physician, go to "Complaint Information" under the Services for Consumers button.

Providing your name and address is optional, but if you wish a reply, please complete.

NAME:	**PHONE:**
ADDRESS:	
Date(s) you contacted the Board if known:	
What is the main reason(s) you contacted the Board?	
Do you recall the unit you contacted or the phone number(s) you called? ○ **Yes** ○ **No** **If so, which unit?** **Phone Number:**	
Whom did you talk to?	
Did you come to one of the Board's offices? ○ **Yes** ○ **No** **If so, which city?**	
Please summarize your contact with the Board and comment on the experience. If you were not satisfied with our service, please suggest how we can improve it. Attach additional pages if necessary.	

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
CENTRAL COMPLAINT UNIT
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2424 FAX (916) 263-2435
www.mbc.ca.gov

REPORTING REQUIREMENTS FOR CORONERS

Pursuant to Section 802.5 of the Business and Professions Code: "When a coroner receives information that is based on findings that were reached by, or documented and approved by a board-certified or board-eligible pathologist indicating that a death may be the result of a physician's or podiatrist's gross negligence or incompetence, a report shall be filed with the Medical Board of California or the California Board of Podiatric Medicine. The initial report shall include the name of the decedent, date and place of death, attending physicians or podiatrists, and all other relevant information available. The initial report shall be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information."

REPORTING ENTITY

CORONER'S OFFICE:_____
ADDRESS:_____ CONTACT PERSON:_____
_____ PHONE:_____
_____ CASE NO:_____

DECEDENT

NAME:_____ DATE OF DEATH:_____
PLACE OF DEATH:_____

PHYSICIAN/PODIATRIST

NAME:_____ MEDICAL LICENSE #:_____
ADDRESS:_____
_____

ATTACHMENTS

CORONER'S REPORT: yes___ no___ AUTOPSY PROTOCOL: yes___ no___

OTHER:

You may use the reverse of this form for a narrative report or you may attach as many pages as necessary for complete documentation of the events that transpired. Thank you for your report.

State of California

State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

DIVISION OF MEDICAL QUALITY

MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

9th Edition

2003

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY

The 21 member Medical Board of California (MBC) is made up of two autonomous divisions. Each division has exclusive jurisdiction over its own specialized area of responsibility: the Division of Licensing (DOL), licensing of physicians, 7 Board members; and the Division of Medical Quality (DMQ), physician discipline, 14 Board members. The DMQ is divided into two panels of seven members for the purpose of deciding disciplinary cases.

The DMQ produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, 9th Edition for the intended use of those involved in the physician disciplinary process: Administrative Law Judges, defense attorneys, physicians-respondents, trial attorneys from the Office of the Attorney General, and DMQ panel members who review proposed decisions and stipulations and make final decisions. These guidelines are not binding standards.

The Federation of State Medical Boards and other state medical boards have requested and received this manual. All are welcome to use and copy any part of this material for their own work.

For additional copies of this manual, please write to:

Medical Board of California
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Phone (916) 263-2466

Revisions to the Manual of Model Disciplinary Orders and Disciplinary Guidelines, are made periodically. Listed below are the most recent changes included in the 9th edition approved by the DMQ following open discussion at a public meeting.

Summary of Changes

Model Condition Number:

1. **Revocation - Single Cause**. No change.

2. **Revocation - Multiple Causes**. No change.

3. **Standard Stay Order**. The suspension option was deleted and language requiring respondent to provide proof of service was incorporated with Model Condition Number # 28- Notification.

4. **Actual Suspension**. No change.

5. **Controlled Substances - Total Restriction**. Changes Controlled Drugs to Controlled Substances. Adds the respondent shall not issue any recommendation or approval which authorizes a patient to possess or cultivate marijuana pursuant to Health and Safety Code section 11362.5.

6. **Controlled Substances - Surrender of DEA Permit**. Changes Controlled Drugs to Controlled Substances. Changes triplicate prescription forms and federal forms to state prescription forms and all controlled substances order forms.

7. **Controlled Substances - Partial Restriction**. Changes Controlled Drugs to Controlled Substances. Adds the respondent shall not issue any recommendation or approval which authorizes a patient to possess or cultivate marijuana pursuant to Health and Safety Code section 11362.5. Deletes optional language which permitted respondent to prescribe, administer, dispense or order controlled substances in a specific Schedule in a specific setting. Adds optional language requiring respondent to surrender respondent's current DEA permit to reapply for a new DEA permit limited to those Schedules authorized by this order; and to submit proof that respondent has surrendered respondent's DEA permit for cancellation and reissuance.

8. **Controlled Substances - Maintain Records and Access to Records and Inventories**. Changes Controlled Drugs to Controlled Substances. Adds that respondent must maintain records of any recommendation or approval which authorizes a patient to possess or cultivate marijuana pursuant to Health and Safety Code section 11362.5; respondent shall keep the records in a separate file or ledger in chronological order; respondent's controlled substances records and inventories shall be available during business hours for inspection and copying on the premises. Makes failure to maintain all records, provide immediate access to the inventory or make all records available for immediate inspection and copying on the premises, a violation of probation.

9. **Controlled Substances - Abstain From Use.** Changes Controlled Drugs to Controlled Substances. Adds provisions that respondent shall notify the Division of the issuing practitioner's name, address, and telephone number; medication name and strength; and issuing pharmacy name, address, and telephone number for any lawful prescription medications received.

10. **Alcohol - Abstain From Use.** Adds that respondent shall abstain from the use of products or beverages containing alcohol.

11. **Biological Fluid Testing.** Adds provisions that a certified copy of a laboratory test result may be received in evidence in any proceedings; and respondent's failure to submit or complete a biological fluid test shall result in a violation of probation.

12. **Diversion Program.** Adds that respondent shall execute a release authorizing the Diversion Program to notify the Division of specified determinations and to provide confirmation respondent shall cease the practice of medicine; if the Diversion Program determines that respondent requires further treatment and rehabilitation, the period of probation shall be extended; if the Diversion Program determines that respondent shall cease the practice of medicine, respondent shall not engage in the practice of medicine; and failure to cooperate or comply with the Diversion Program shall result in a violation of probation.

13. **Community Service - Free Services.** Adds that respondent shall submit a plan to complete community service within a specified period; respondent shall provide a copy of the Decision(s) to the Chief of Staff, Director, Office Manager, Program Manager, Officer, or the Chief Executive Officer at every community or non-profit organization where respondent provides community services and provide proof of compliance to the Division; and community service performed prior to the effective date of the Decision will not be accepted.

14. **Education Course.** Specifies that within 60 calendar days of the effective date of the Decision, respondent shall submit an educational program and the educational courses shall be limited to classroom, conference or seminar settings that are Category I certified Continuing Medical Education (CME).

15. **Prescribing Practices Course.** Adds provisions that the Prescribing Practices Course must be completed during the first 6 months of probation. A Prescribing Practices Course taken after the acts that gave rise to the Accusation, but prior to the effective date of the Decision may be accepted. Respondent shall submit a certification of completion not later than 15 calendar days after successfully completing the course, or not later that 15 calendar days after the effective date of the Decision, whichever is later.

16. **Medical Record Keeping Course.** New. Adds provisions that the Medical Record Keeping Course must be completed during the first 6 months of probation. A Medical Record Keeping Course taken after the acts that gave rise to the Accusation, but prior to the effective date of the Decision may be accepted. Respondent shall submit a certification of completion not later than

15 calendar days after successfully completing the course, or not later that 15 calendar days after the effective date of the Decision, whichever is later.

17. **Ethics Course**. Adds that an Ethics Course taken after the acts that gave rise to the Accusation, but prior to the effective date of the Decision may be accepted. Respondent shall submit a certification of completion not later than 15 calendar days after successfully completing the course, or not later that 15 calendar days after the effective date of the Decision, whichever is later.

18. **Professional Boundaries Program**. New. Adds provisions that within a specified period, respondent shall enroll in a professional boundaries program, at respondent's expense, equivalent to the Professional Boundaries Program at the University of California, San Diego School of Medicine ("Program"); specifies Program components; requires respondent to successfully complete the components; failure to participate in and complete successfully the Program shall result in a violation of probation; and adds two optional conditions.

19. **Clinical Training Program**. Specifies that within 60 calendar days from the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program"). The Program shall consist of a comprehensive assessment and clinical education. Failure to participate in and complete successfully all of the Clinical Training Program is a violation of probation. Adds three optional conditions.

20. **Oral or Written Examination**. Adds that within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Probation Unit; the Division or its designee shall administer the oral and/or written examination; the oral examination shall be audio tape recorded; and specifies that respondent is allowed two attempts within the first 180 days of probation to pass an oral and/or written examination.

21. **Psychiatric Evaluation**. Adds that prior to the psychiatric evaluation the board certified psychiatrist shall consider any information provided by the Division or its designee and any other information and documents that the psychiatrist may deem pertinent; psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement; and failure to undergo and complete a psychiatric evaluation and psychological testing, or comply with the required additional conditions or restrictions shall result in a violation of probation.

22. **Psychotherapy**. Adds that respondent shall submit the name and qualifications of a board certified psychiatrist or a licensed psychologist with specified qualifications; the frequency of psychotherapy may be modified; prior to the commencement of psychotherapy, the psychotherapist shall consider any information provided by the Division or its designee and any other information and documents that the psychotherapist may deem pertinent; respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent; and failure to undergo and continue psychotherapy

treatment, or comply with any required modification in the frequency of psychotherapy is a violation of probation.

23. **Medical Evaluation and Treatment**. Adds that the evaluating physician shall consider any information provided by the Division or its designee prior to respondent's evaluation; following the evaluation, the Division shall determine whether or not additional conditions or restrictions need to be placed on respondent to ensure respondent's ability to practice medicine safely; respondent shall be notified in writing of the required additional conditions or restrictions; respondent shall comply with the additional conditions and restrictions within 15 calendar days. Adds that if respondent is required to undergo medical treatment, respondent shall within a specified period submit to the Division for prior approval the name and qualifications of a treating physician of respondent's choice; upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice; the treating physician shall consider any information provided by the Division or its designee and any other information the treating physician may deem pertinent prior to the treating physician's evaluation; respondent shall have the treating physician submit written quarterly reports to the Division indicating whether or not the respondent is capable of practicing medicine safely; respondent shall provide the Division with any and all medical records pertaining to treatment that the Division deems necessary; and failure to undergo and continue medical treatment or comply with the required additional conditions or restrictions shall result in a violation of probation.

24. **Monitoring - Practice/Billing**. Specifies that the respondent shall provide the name and qualifications of one or more licensed physicians and surgeons to act as a monitor(s) whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified; a monitor shall have no prior or current business or personal relationship with respondent or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, and be in respondent's field of practice. The Division shall provide the monitor with copies of the Decision(s) and Accusation(s) and proposed monitoring plan; the monitor shall sign a written statement that the monitor has read the Decision(s) and Accusation(s) and fully understands the role of a practice monitor and agrees or disagrees with the proposed monitoring plan. Respondent shall provide the monitor access to respondent's patient records; if the monitor resigns or is no longer available, respondent shall submit within 5 calendar days the name and qualifications of a replacement monitor; if respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Adds that in lieu of a monitor respondent may participate in a professional enhancement program as specified. Optional condition regarding the prohibition of solo practice was moved to condition 25.

25. **Solo Practice**. Formerly part of optional language in Monitoring condition, specified that respondent is prohibited from engaging in the solo practice of medicine.

26. **Third Party Chaperone**. Adds that the third party chaperone(s) shall initial and date each patient medical record at the time the chaperone's services are provided, and read the Decision(s) and the Accusation(s). Adds that respondent shall maintain a specified log of all patients seen for whom a third party chaperone is required; keep this log in a separate file or ledger, in chronological order, and available for immediate inspection and copying on the premises by the Division; and failure to maintain a log of all patients seen for whom a third party chaperone is required, or to make the log available for immediate inspection and copying on the premises, is a violation of probation. Adds new option requiring respondent to provide written notification to respondent's patients that a third party chaperone shall be present during all consultation, examinations, or treatment; respondent shall maintain a copy of the notification in the patient's file, and the notification shall be available for immediate inspection and copying on the premises during business hours by the Division during the term of probation, and shall be retained for the entire term of probation.

27. **Prohibited Practice**. Adds that respondent shall provide an oral and written notification to respondent's patients that respondent does not practice, perform or treat a specified procedure on a specified patient population. Respondent shall maintain a specified log of the oral notification, and maintain the written notification in the patient's file; these shall be available for immediate inspection and copying on the premises during business hours by the Division, and shall be retained for the entire term of probation.

28. **Notification**. Formerly part of Standard Stay Order. Specifies that prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision(s) and Accusation(s) at any facility where respondent engages in the practice of medicine to include all physician and locum tenens registries or other similar agencies; respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. Specifies this condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

29. **Supervision of Physician Assistants**. Renumbered.

30. **Obey All Laws**. No change.

31. **Quarterly Declaration**. Adds a new provision that respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

32. **Probation Unit Compliance**. Deleted surveillance program from name. Specifies respondent shall not engage in the practice of medicine in respondent's place of residence.

33. **Interview with the Division or its Designee**. Adds that respondent shall be available in person for interviews either at respondent's place of business or at the Probation Unit office either with or without prior notice.

34. **Residing or Practicing Out-of-State**. Specifies that if respondent leaves the State of California to reside or practice, respondent shall notify the Division prior to the date of departure or return. If respondent's periods of temporary or permanent residence or practice

outside California total two years, respondent's license shall be automatically cancelled. Periods of temporary or permanent residence or practice outside California shall not relieve respondent of the responsibility to comply with specified terms and conditions. For those licenses disciplined pursuant to Business and Professions Code sections 141(a) and 2305, the two year period begins on the date probation is completed in that state.

35. **Failure to Practice Medicine** - California Resident. New, replaces old condition of Tolling of Probation. If respondent resides in California and stops practicing medicine for a total of two years, respondent's license shall be automatically cancelled; periods of non-practice shall not relieve respondent of the responsibility to comply with specified terms and conditions.

36. **Completion of Probation**. Adds that respondent shall comply with all financial obligations not later than 120 calendar days prior to the completion of probation.

37. **Violation of Probation**. Adds that failure to fully comply with any term or condition of probation is a violation of probation.

38. **Cost Recovery**. Adds that respondent shall reimburse the Division for its prosecution costs.

39. **License Surrender**. Adds that upon formal acceptance of the surrendered license, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division and respondent shall no longer be able to practice medicine; the surrender of respondent's license shall be deemed disciplinary action; if respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

40. **Probation Monitoring Costs**. Technical changes only.

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
DIVISION OF MEDICAL QUALITY

MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Division of Medical Quality (DMQ) and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the DMQ has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), 9th Edition. Consistent with the mandates of section 2229, these guidelines set forth the discipline the DMQ finds appropriate and necessary for the identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the DMQ finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.

The DMQ expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility and demonstrated willingness to undertake DMQ ordered rehabilitation, Administrative Law Judges hearing cases on behalf of the DMQ and proposed settlements submitted to the DMQ will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

The Model Disciplinary Orders contain three sections: three (3) Disciplinary Orders; twenty-four (24) Optional Conditions whose use depends on the nature and circumstances of the particular case; and thirteen (13) Standard Conditions that generally appear in all probation cases. All orders should place the Order(s) first, optional condition(s) second, and standard conditions third.

The Model Disciplinary Guidelines list proposed terms and conditions for more than twenty-four (24) sections of the Business and Professions Code.

MODEL DISCIPLINARY ORDERS

INDEX

STANDARD CONDITIONS

MODEL DISCIPLINARY ORDERS

1. Revocation - Single Cause

Certificate No._____ issued to respondent _____ is revoked.

2. Revocation - Multiple Causes

Certificate No. _____ issued to respondent _____ is revoked pursuant to Determination of Issues (e.g. I, II, and III), separately and for all of them.

3. Standard Stay Order

However, revocation stayed and respondent is placed on probation for (e.g., ten) years upon the following terms and conditions.

OPTIONAL CONDITIONS

4. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for (e.g., 90 days) beginning the sixteenth (16th) day after the effective date of this decision.

5. Controlled Substances - Total Restriction

Respondent shall not order, prescribe, dispense, administer, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section11362.5. If respondent forms the medical opinion, after a good faith prior examination, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following a good faith examination, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

6. Controlled Substances - Surrender of DEA Permit

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Division or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Division or its designee.

7. Controlled Substances - Partial Restriction

Respondent shall not order, prescribe, dispense, administer, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s)_____(e.g., IV and V) of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section11362.5. If respondent forms the medical opinion, after a good faith prior examination, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following a good faith examination, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Note: Also use Condition 8, which requires that separate records be maintained for all controlled substances prescribed.

(Option)
Respondent shall immediately surrender respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, respondent shall submit proof that respondent has surrendered respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, the respondent shall submit a true copy of the permit to the Division or its designee.

8. Controlled Substances- Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Division or its designee at all times during business hours and shall be retained for the entire term of probation.

Failure to maintain all records, to provide immediate access to the inventory, or to make all records available for immediate inspection and copying on the premises, is a violation of probation.

9. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawful prescription medications, respondent shall notify the Division or its designee of the: issuing practitioner's name, address, and telephone number; medication name and strength; and issuing pharmacy name, address, and telephone number.

10. Alcohol - Abstain From Use

Respondent shall abstain completely from the use of products or beverages containing alcohol.

11. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon the request of the Division or its designee. A certified copy of any laboratory test results may be received in evidence in any proceedings between the Board and the respondent. Failure to submit to, or failure to complete the required biological fluid testing, is a violation of probation.

12. Diversion Program

Within 30 calendar days from the effective date of this Decision, respondent shall enroll and participate in the Board's Diversion Program until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Upon enrollment, respondent shall execute a release authorizing the Diversion Program to notify the Division of the following: 1) respondent requires further treatment and rehabilitation; 2) respondent no longer requires treatment and rehabilitation; and 3) respondent may resume the practice of medicine. Respondent shall execute a release authorizing the Diversion Program to provide confirmation to the Division whenever the Diversion Program has determined that respondent shall cease the practice of medicine.

Within 5 calendar days after being notified by the Diversion Program of a determination that further treatment and rehabilitation are necessary, respondent shall notify the Division in writing. The Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Diversion Program determines that further treatment and rehabilitation are no longer necessary. Within 24 hours after being notified by the Diversion Program of a determination that respondent shall cease the practice of medicine, respondent shall notify the Division and respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of the Diversion Program's determination that respondent may resume the practice of medicine. Failure to cooperate or comply with the Diversion Program requirements and recommendations, quitting the program without permission, or being expelled for cause is a violation of probation.

13. Community Service - Free Services

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval a community service plan in which respondent shall within the first 2 years of probation, provide_____ hours of free-services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service and shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition. Note: In quality of care cases, only non-medical community service is allowed unless respondent passes a competency exam or otherwise demonstrates competency prior to providing community service.

14. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Division or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified, limited to classroom, conference, or seminar settings. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Division or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

15. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

16. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first 6 months of probation is a violation of probation.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee

not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

17. Ethics Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in ethics, at respondent's expense, approved in advance by the Division or its designee. Failure to successfully complete the course during the first year of probation is a violation of probation.

An ethics course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Division or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

18. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program, at respondent's expense, equivalent to the Professional Boundaries Program, Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program"). Respondent, at the Program's discretion, shall undergo and complete the Program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Division or its designee deems relevant. The Program shall evaluate respondent at the end of the training and the Program shall provide any data from the assessment and training as well as the results of the evaluation to the Division or its designee.

Failure to complete the entire Program not later than six months after respondent's initial enrollment shall constitute a violation of probation unless the Division or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the Program shall advise the Division or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with Program recommendations. At the completion of the Program, respondent shall submit to a final evaluation. The Program shall provide the results of the evaluation to the Division or its designee.

The Program's determination whether or not respondent successfully completed the Program shall be binding.

Failure to participate in and complete successfully all phases of the Program, as outlined above, is a violation of probation.

(Option # 1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Division or its designee in writing.

(Option # 2: Condition Subsequent)
If respondent fails to complete the Program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Division or its designee that respondent failed to complete the Program.

19. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. The Program's determination whether or not respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and complete successfully all phases of the clinical training program outlined above is a violation of probation.

(Option #1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Division or its designee in writing, except that respondent may practice in a clinical training program approved by the Division or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

(Option#2: Condition Subsequent)
If respondent fails to complete the clinical training program within the designated time period, respondent shall cease the practice of medicine within 72 hours after being notified by the Division or its designee that respondent failed to complete the clinical training program.

(Option#3)
After respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Division or its designee determines that further participation is no longer necessary.

Failure to participate in and complete successfully the professional enhancement program outlined above is a violation of probation.

20. Oral and/or Written Examination

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or written examination, administered by the Probation Unit. The Division or its designee shall administer the oral and/or written examination in a subject to be designated by the Division or its designee and the oral examination shall be audio tape recorded.

If respondent fails the first examination, respondent shall be allowed to take and pass a second examination, which may consist of an oral and/or written examination. The waiting period between the first and second examinations shall be at least 90 calendar days.

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations. For purposes of this condition, if respondent is required to take and pass a written exam, it shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Division or its designee.

(Continue with either one of these two options:)

(Option 1: Condition Precedent)
Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Division or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the Division or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

(Option 2: Condition Subsequent)
If respondent fails to pass the first examination, respondent shall be suspended from the practice of medicine. Respondent shall cease the practice of medicine within 72 hours after being notified by the Division or its designee that respondent has failed the examination. Respondent shall remain suspended from the practice of medicine until respondent successfully passes a repeat examination, as evidenced by written notice to respondent from the Division or its designee.

21. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on ~~a~~ whatever periodic basis thereafter may be required by the Division or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Division-appointed board certified psychiatrist, who shall consider any information provided by the Division or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Division or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Division or its designee. Failure to undergo and complete a psychiatric evaluation and psychological testing, or comply with the required additional conditions or restrictions, is a violation of probation.

(Option: Condition Precedent)
Respondent shall not engage in the practice of medicine until notified by the Division or its designee that respondent is mentally fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation.

22. Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval the name and qualifications of a board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Division or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Division or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Division or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent. Respondent shall have the treating psychotherapist submit quarterly status reports to the Division or its designee. The Division or its designee may require respondent to undergo psychiatric evaluations by a Division-appointed board certified psychiatrist.

If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Division determines that respondent is mentally fit to resume the practice of medicine without restrictions. Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

Failure to undergo and continue psychotherapy treatment, or comply with any required modification in the frequency of psychotherapy, is a violation of probation.

Note: This condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or drug self-abuse) related to the violations but is not at present a danger to respondent's patients.

23. Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Division or its designee, respondent shall undergo a medical evaluation by a Division-appointed physician who shall consider any information provided by the Division or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Division or its designee.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Division or its designee.

If respondent is required by the Division or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the Division or

its designee for prior approval the name and qualifications of a treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Division or its designee.

The treating physician shall consider any information provided by the Division or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Division or its designee indicating whether or not the respondent is capable of practicing medicine safely. Respondent shall provide the Division or its designee with any and all medical records pertaining to treatment, that the Division or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Division shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Division determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

Failure to undergo and continue medical treatment or comply with the required additional conditions or restrictions is a violation of probation.

(Option- Condition Precedent)
Respondent shall not engage in the practice of medicine until notified in writing by the Division or its designee of its determination that respondent is medically fit to practice safely.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

24. Monitoring - Practice/Billing

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a _____(i.e., practice, billing, or practice and billing) monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor

disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's _____ (i.e., practice, billing, or practice and billing) shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor(s) shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

In lieu of a monitor, respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

25. Solo Practice

Respondent is prohibited from engaging in the solo practice of medicine.

26. Third Party Chaperone

During probation, respondent shall have a third party chaperone present while consulting, examining or treating _____(e.g., male, female, or minor) patients. Respondent

shall, within 30 calendar days of the effective date of the Decision, submit to the Division or its designee for prior approval name(s) of persons who will act as the third party chaperone. Each third party chaperone shall initial and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient name, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Division or its designee, and shall retain the log for the entire term of probation. Failure to maintain a log of all patients requiring a third party chaperone, or to make the log available for immediate inspection and copying on the premises, is a violation of probation.

(Option)
Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with (e.g., male, female or minor) patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Division or its designee, and shall retain the notification for the entire term of probation.

Note: Sexual offenders should normally be placed in a monitored environment.

27. Prohibited Practice

During probation, respondent is prohibited from _____(e.g., practicing, performing, or treating) _____ (e.g., a specific medical procedure; surgery; on a specific patient population). After the effective date of this Decision, the first time that a patient seeking the prohibited services makes an appointment, orally notify the patient that respondent does not _____(e.g., practice, perform or treat) _____(e.g., a specific medical procedure; surgery; on a specific patient population). Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Division or its designee, and shall retain the log for the entire term of probation. Failure to maintain a log as defined in the section, or to make the log available for immediate inspection and copying on the premises during business hours is a violation of probation.

In addition to the required oral notification, after the effective date of this Decision, the first time that a patient who seeks the prohibited services presents to respondent, respondent shall provide a written notification to the patient stating that respondent does not

_____(e.g., practice, perform or treat)_____(e.g., a specific medical procedure; surgery; on a specific patient population). Respondent shall maintain a copy of the written notification in the patient's file, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Division or its designee, and shall retain the notification for the entire term of probation. Failure to maintain the written notification as defined in the section, or to make the notification available for immediate inspection and copying on the premises during business hours is a violation of probation.

STANDARD CONDITIONS

28. Notification

Prior to engaging in the practice of medicine the respondent shall provide a true copy of the Decision(s) and Accusation(s) to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

29. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants.

30. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

31. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

32. Probation Unit Compliance

Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

33. Interview with the Division or its Designee

Respondent shall be available in person for interviews either at respondent's place of business or at the probation unit office, with the Division or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

34. Residing or Practicing Out-of-State

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

(Optional)
Any respondent disciplined under B&P Code sections 141(a) or 2305 (another state discipline) may petition for modification or termination of penalty: 1) if the other state's discipline terms are modified, terminated or reduced; and 2) if at least one year has elapsed from the effective date of the California discipline.

35. Failure to Practice Medicine - California Resident

In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

36. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

37. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

38. Cost Recovery

Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, respondent shall reimburse the Division the amount of $_____ for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by respondent shall not relieve the respondent his/her obligation to reimburse the Division for its costs.

39. License Surrender

Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation,

respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

40. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DISCIPLINARY GUIDELINES
INDEX

DISCIPLINE BY ANOTHER STATE [B&P 141(a) & 2305]

Minimum penalty: Same for similar offense in California
Maximum penalty: Revocation
1. Oral or Written Examination as a condition precedent to practice in California [20]

MISLEADING ADVERTISING (B&P 651 & 2271)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [14]
3. Ethics Course [17]
4. Monitoring-Practice/Billing [24]
5. Prohibited Practice [27]

EXCESSIVE PRESCRIBING (B&P 725), or
PRESCRIBING WITHOUT A PRIOR EXAMINATION (B&P 2242)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5],
   Surrender DEA permit [6] or,
   Partial DEA restriction [7]
3. Maintain Records and Access to Records and Inventories [8]
4. Education Course [14]
5. Prescribing Practices Course [15]
6. Medical Record Keeping Course [16]
7. Ethics Course [17]
8. Clinical Training Program [19] or Oral or Written Examination [20]
9. Monitoring - Practice/Billing [24]

EXCESSIVE TREATMENTS (B&P 725)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [14]
3. Medical Record Keeping Course [16]
4. Ethics Course [17]
5. Clinical Training Program [19] or Oral or Written Examination [20]
6. Monitoring - Practice/Billing [24]
7. Prohibited Practice [27]

SEXUAL MISCONDUCT (B&P 726)

Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [14]
3. Ethics Course [17]
4. Professional Boundaries Program [18]
5. Psychiatric Evaluation [21]
6. Psychotherapy [22]
7. Monitoring-Practice/Billing [24]
8. Third Party Chaperone [26]
9. Prohibited Practice [27]

SEXUAL EXPLOITATION (B&P 729)

Effective January 1, 2003, Business and Professions Code 2246 was added to read, "Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge."

MENTAL OR PHYSICAL ILLNESS (B&P 820)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Diversion Program [12]
2. Oral or Written Examination [20]
3. Psychiatric Evaluation [21]
4. Psychotherapy [22]
5. Medical Evaluation and Treatment [23]
6. Monitoring-Practice/Billing [24]
7. Solo Practice [25]
8. Prohibited Practice [27]

GENERAL UNPROFESSIONAL CONDUCT (B&P 2234), or
GROSS NEGLIGENCE [B&P 2234 (b)], or
REPEATED NEGLIGENT ACTS [B&P 2234(c)], or
INCOMPETENCE [B&P 2234(d)], or
FAILURE TO MAINTAIN ADEQUATE RECORDS (B&P 2266)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Education course [14]
2. Prescribing Practices Course [15]
3. Medical Record Keeping Course [16]
4. Ethics Course [17]
5. Clinical Training Program [19]
6. Oral or Written Examination [20] (preferably Condition Precedent)
7. Monitoring - Practice Billing [24]
8. Solo Practice [25]
9. Prohibited Practice [27]

DISHONESTY - Substantially related to the qualifications, functions or duties of a physician and surgeon and arising from or occurring during patient care, treatment, management or billing [B&P 2234(e)]

Minimum penalty: Stayed revocation, one year suspension at least 7 years probation
Maximum penalty: Revocation

1. Ethics Course [17]
2. Oral or Written Examination [20]
3. Psychiatric Evaluation [21]
4. Medical Evaluation [23]
5. Monitoring-Practice/Billing [24]
6. Solo Practice [25]
7. Prohibited Practice [27]

DISHONESTY - Substantially related to the qualifications, function or duties of a physician and surgeon but not arising from or occurring during patient care, treatment, management or billing [BP 2234 (e)]

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Ethics Course [17]
3. Psychiatric Evaluation [21]
4. Medical Evaluation [23]
5. Monitoring-Practice/Billing (if financial dishonesty or conviction of financial crime) [24]
6. Restitution to Victim

PROCURING LICENSE BY FRAUD (B&P 2235)

1. Revocation [1] [2]

CONVICTION OF CRIME - Substantially related to the qualifications, functions or duties of a physician and surgeon and arising from or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, one year suspension, at least 7 years probation
Maximum penalty: Revocation

1. Ethics Course [17]
2. Oral or Written Examination [20]
3. Psychiatric Evaluation [21]
4. Medical Evaluation and Treatment [23]
5. Monitoring-Practice/Billing [24]
6. Solo Practice [25]
7. Prohibited Practice [27]

CONVICTION OF CRIME - Felony conviction substantially related to the qualifications, functions or duties of a physician and surgeon but not arising from or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, 7 years probation
Maximum penalty: Revocation

1. Suspension of 30 days or more [4]
2. Ethics Course [17]
3. Psychiatric Evaluation [21]
4. Medical Evaluation and Treatment [23]
5. Monitoring-Practice/Billing (if dishonesty or conviction of a financial crime) [24]
6. Victim Restitution

CONVICTION OF CRIME - Misdemeanor conviction substantially related to the qualifications, functions or duties of a physician and surgeon but not arising from or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Ethics Course [17]
2. Psychiatric Evaluation [21]
3. Medical Evaluation and Treatment [23]
4. Victim Restitution

CONVICTION OF DRUG VIOLATIONS (B&P 2237), or
VIOLATION OF DRUG STATUTES (B&P 2238), or
EXCESSIVE USE OF CONTROLLED SUBSTANCES (B&P 2239), or
PRACTICE UNDER THE INFLUENCE OF NARCOTIC (B&P 2280)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5],
   Surrender DEA permit [6], or
   Partial DEA restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Controlled Substances - Abstain From Use [9]
5. Alcohol-Abstain from Use [10]
6. Biological Fluid Testing [11]
7. Diversion Program [12]
8. Education Course [14]
9. Prescribing Practices Course [15]
10. Medical Record Keeping Course [16]
11. Ethics Course [17]
12. Oral or Written Examination [20]
13. Psychiatric Evaluation [21]
14. Psychotherapy [22]
15. Medical Evaluation and Treatment [23]
16. Monitoring-Practice/Billing [24]
17. Prohibited Practice [27]

ILLEGAL SALES OF CONTROLLED SUBSTANCES (B&P 2238)
Revocation [1] [2]

EXCESSIVE USE OF ALCOHOL (B&P 2239) or
PRACTICE UNDER THE INFLUENCE OF ALCOHOL (B&P 2280)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances-Abstain From Use [9]
3. Alcohol-Abstain from Use [10]
4. Biological Fluid Testing [11]
5. Diversion Program [12]
6. Ethics Course [17]
7. Oral or Written Examination [20]
8. Psychiatric Evaluation [21]
9. Psychotherapy [22]
10. Medical Evaluation and Treatment [23]
11. Monitoring-Practice/Billing [24]

PRESCRIBING TO ADDICTS (B&P 2241)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances- Total DEA restriction [5],
   Surrender DEA permit [6], or
   Partial restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Education Course [14]
5. Prescribing Practices Course [15]
6. Medical Record Keeping Course [16]
7. Ethics Course [17]
8. Clinical Training Program [19]
9. Oral or Written Examination [20]
10. Monitoring-Practice/Billing [24]
11. Prohibited Practice [27]

ILLEGAL CANCER TREATMENT (B&P 2252)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education course [14]
3. Ethics Course [17]
4. Clinical Training Program [19]
5. Oral or Written Examination [20]
6. Monitoring-Practice/Billing [24]
7. Prohibited Practice [27]

MAKING FALSE STATEMENTS (B&P 2261), or
ALTERATION OF MEDICAL RECORDS (B&P 2262)

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Ethics Course [17]
3. Medical Record Keeping Course [16]
4. If fraud involved, see "Dishonesty" guidelines

AIDING AND ABETTING UNLICENSED PRACTICE (B&P 2264)
Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [14]
3. Ethics Course [17]
4. Oral or Written Examination [20]
5. Monitoring-Practice/Billing [24]
6. Prohibited Practice [27]

FICTITIOUS NAME VIOLATION (B&P 2285)
Minimum penalty: Stayed revocation, one year probation
Maximum penalty: Revocation

IMPERSONATION OF APPLICANT IN EXAM (B&P 2288)
1. Revocation [1] [2]

PRACTICE DURING SUSPENSION (B&P 2306)
1. Revocation [1] [2]

BUSINESS ORGANIZATION IN VIOLATION OF CHAPTER (B&P 2417)
Effective January 1, 2002, Business and Professions Code section 2417 was added to read, in part, "(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of Section 1871.4 of the Insurance Code, Section 14107 or 14107.2 of the Welfare and Institutions Code, or Section 549 or 550 of the Penal Code shall have his or her license to practice permanently revoked."

VIOLATION OF PROBATION
Minimum penalty: 30 day suspension
Maximum penalty: Revocation

The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude.

A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:

Controlled Substances -Maintain Records and Access to Records and Inventories [8]
Biological Fluid Testing [11]
Diversion Program [12]
Professional Boundaries Program [18]
Clinical Training Program [19]
Psychiatric Evaluation [21]
Psychotherapy [22]
Medical Evaluation and Treatment [23]
Third Party Chaperone [26]

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2434 FAX (916) 263-2435
www.caldocinfo.ca.gov

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians and podiatrists must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason. Reports on osteopathic physicians, dentists and psychologists should be directed to their respective Boards. Please see the reverse/second page of this form for further information.

******PLEASE PRINT OR TYPE******

REPORTING ENTITY

Please check type of Reporting Entity: ○ Health Care Facility or Clinic - §805(a)(1)(A) ○ Health Care Service Plan - §805(a)(1)(B) ○ Professional Society - §805(a)(1)(C) ○ Medical Group or Employer - §805(a)(1)(D)

Name	Telephone #:
Chief Executive Officer/Medical Director/Administrator	Chief of Medical Staff
Name of person preparing report:	Telephone #
street address city state zip code	

LICENTIATE

Name (Last) (First) License #

Physician ○ Podiatrist ○

ACTION TAKEN

Date(s) of Action(s) and Duration (attached additional sheets if necessary)

Type(s) of Action(s) - Check all that apply. **CHECK HERE IF THIS IS A SUPPLEMENTAL REPORT** ☐

(a) For a medical disciplinary cause or reason:
_____ Denial/rejection of application for staff privileges
_____ Denial/rejection of application for membership
_____ Termination or revocation of staff privileges
_____ Termination or revocation of membership
_____ Termination or revocation of employment

(b) For a cumulative total of 30 days or more for any 12 month period, and for a medical disciplinary cause or reason:
_____ Restriction(s) imposed on staff privileges
_____ Restriction(s) imposed on membership
_____ Restriction(s) imposed on employment
_____ Restriction(s) voluntarily accepted on staff privileges
_____ Restriction(s) voluntarily accepted on membership
_____ Restriction(s) voluntarily accepted on employment

If staff privileges were restricted, list specific restrictions imposed or voluntarily accepted:

(c) Following notice of an impending investigation based on information indicating medical disciplinary cause or reason:
_____ Licentiate resigned from staff
_____ Licentiate resigned from membership
_____ Licentiate resigned from employment
_____ Licentiate took leave of absence from staff
_____ Licentiate took leave of absence from membership
_____ Licentiate took leave of absence from employment

(d) For a summary suspension that remains in effect for a period in excess of 14 days for a medical disciplinary cause or reason:
_____ Imposition of summary suspension on staff privileges
_____ Imposition of summary suspension on membership
_____ Imposition of summary suspension on employment

DESCRIPTION OF ACTION: Attach additional sheet(s) describing the facts and circumstances of the medical disciplinary cause or reason and any other relevant information related to the action taken, including, but not limited to, the number of cases reviewed, time frame covered, any patient deaths involved, any malpractice filings as a result of the physician's actions, any expert/peer opinions obtained, etc.

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

ADDITIONAL INFORMATION

To complete this form, for definition of terms, when, how, and who should report, please refer to Section 805 of the California Business and Professions Code. You may access this information via www.leginfo.ca.gov under California Law, Business and Professions Code.

PLEASE NOTE: Section 805(k) of the California Business and Professions Code states: "A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, 'willful' means a voluntary and intentional violation of a known legal duty."

Section 805(l) of the California Business and Professions Code states: "Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that, under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code."

Section 805(m) of the California Business and Professions Code states: "A health care service plan registered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates."

CONFIDENTIALITY

This report is not a waiver of the confidentiality of medical records and committee reports. The contents of this report may be viewed only by those persons specified in Section 800(c) of the Business and Professions Code, except as required by Section 805.5 of the Business and Professions Code.

COPY TO LICENTIATE

A copy of the 805 report, with a cover letter informing the Licentiate of his or her right to submit additional statements or other information pursuant to Section 800(c) of the Business and Professions Code, must be sent by the reporting entity to the Licentiate.

SUPPLEMENTAL REPORT

A supplemental report must be made within thirty (30) days following the date the Licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as corrective action by the reporting entity.

MEDICAL BOARD OF CALIFORNIA

Peer Review Body Initial Report Form to the Physician Diversion Program Regarding an Investigation of a Mentally or Physically Disabled Physician

Name of Physician:_____ Medical License #:_____
Specialty:_____
Office Address: _____
_____ Telephone #:_____

Name of Reporting Entity: _____

Address: _____

Contact Person:_____ Telephone #: _____
(Please Print Name and Title)

Briefly Describe the reason for the investigation, including why a mental or physical disorder that may pose a threat to patient care is suspected: _____

Proposed Time Line for Investigation: **Date:**

1. Initiate Formal Investigation. _____
2. Gather Facts about the Problem. _____
   Must be completed within 30 days of Date Formal Investigation Initiated.
3. Request Psychiatric and/or Physical Evaluation, if appropriate. _____
4. Review Findings and Make Decision Regarding Disposition of Case. _____
   Must be completed within 45 days (if no evaluation necessary) or within 75 days (if evaluation(s) necessary) of Date Formal Investigation Initiated.
5. Inform MBC and Physician of Investigation Outcome. _____
   Must be completed within 15 days of Disposition Decision.

_____ _____
Signature Date Signature Date
C.E.O./ Medical Director/ Administrator Chief of Medical Staff (if any)

_____ _____
Print Name and Title Print Name and Title

Note: The information requested on this form is per authority of Section 821.5 of the Business & Professions Code.

MEDICAL BOARD OF CALIFORNIA

Peer Review Body Final Report Form to the Physician Diversion Program Regarding an Investigation of a Mentally or Physically Disabled Physician

Name of Physician: _____ Medical License #:_____
Specialty:_____
Office Address:_____

Name of Reporting Entity: _____
Address:_____
Contact Person:_____Telephone #:_____
(Please Print Name and Title)

Disposition of the Case:

1. No Problems Exist.____ Explain _____

2. These Problems Exist (indicate mental or physical disorder diagnosis, if applicable):_____

3. If a Mental or Physical Disorder exists, is there a threat to patient care? _____ Explain _____

4. The following Action Plan has been implemented: Check all that apply:

a. The physician is undergoing treatment for the disorder. Explain. _____

b. The physician will be monitored. Describe monitoring plan _____

c. Practice restrictions or conditions have been summarily imposed. Explain. _____

d. Practice restrictions or conditions have been recommended and the physician has been offered a hearing under B&P Code Section 809.1. Explain. _____

e. An 805 Report has been filed. Explain. _____

f. Other. Explain. _____

Signature C.E.O./ Medical Director/ Administrator	Date	Signature Chief of Medical Staff (if any)	Date
Print Name and Title		Print Name and Title	

Note: The information requested on this form is per authority of Section 821.5 of the Business & Professions Code

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

CENTRAL COMPLAINT UNIT
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2424 FAX (916) 263-2435
www.mbc.ca.gov

REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD

Required by Section 801.01 California Business and Professions Code

PLEASE CHECK THE APPROPRIATE BOX:

☐ Section 801.01 (b)(1) (Insurance Company) ☐ Section 801.01 (b)(2) (Self-insured) ☐ Plaintiff Attorney (Section 801.01 (e))
☐ Section 801.01 (b)(3) (State or Local Government) ☐ Section 801.01 (c) (Employer-Prof. Corp., group practice, health care facility or clinic)

****PLEASE PRINT OR TYPE****

REPORTING ENTITY:

1. Company Name _____
2. Name of Person Preparing Report _____ Telephone _____
3. Address _____

PHYSICIAN/PROVIDER:

4. Name _____
5. License Number _____
6. Specialty/subspecialty _____
7. Address(es) _____
8. Defense Counsel Name _____
9. Defense Counsel Phone Number _____
10. Address _____
11. NOTE: On reverse, enter full name(s), license numbers and specialty of other physicians, podiatrists or physicians assistants against whom a settlement (over $30,000), a judgment or arbitration award (any amount) was rendered. Enter the amount paid and the type of the award paid on behalf of each provider.

PLAINTIFF/CLAIMANT:

12. Name _____
13. Address _____
14. Relationship to patient _____
15. Patient Name _____
16. Patient Date of Birth _____
17. Medical Record Number _____
18. Deceased ☐ Yes ☐ No
19. Specific Incident Date(s) _____
20. Hospital Name _____ and address _____
21. Date of Admittance _____
22. Plaintiff's Counsel Name _____
23. Plaintiff's Counsel Phone Number _____
24. Plaintiff's Counsel Address _____

25. On the reverse/second page of this form, enter a comprehensive description or summary of the facts upon which each claim, charge or judgment rested including date of occurrence. Explain specifically whether death or personal injury occurred as a result of the negligence, error or omission in practice, or rendering of unauthorized professional services by the insured. Attach additional sheets as necessary. Photocopies of any pertinent documents which contain this information may be attached instead.

26. Case Resulted in: (Check one) ○Settlement ○Judgment ○Arbitration Award	27. Date Resolved:	28. Total Amount of Award: $	29. Total Paid on Behalf of Physician:

30. Name and Location of Court/Arbitrator:	31. Filing Date:	32. Docket Number:

****PLEASE SEE REVERSE/SECOND PAGE OF FORM REGARDING MEDICAL RECORDS****

I certify under penalty of perjury under the laws of the State of California that to the best of my knowledge the information provided within this report and any attachments is true and correct.

_____
Signature of Preparer Date

REVERSE/SECOND PAGE-REPORT OF SETTLEMENT, JUDGMENT OR ARBITRATION AWARD

11. (Continued):

Provider's Name	License #	Specialty	Amount Paid
			$_____ ○ Settlement ○ Judgment ○ Arbitration Award
			$_____ ○ Settlement ○ Judgment ○ Arbitration Award

25. (Continued):

Enter a comprehensive description or summary of facts, describing the specific complaint or allegations of negligence or misconduct by the provider which resulted in the filing of the malpractice claim. Provide specific time frames and indicate if a death occurred.

****PLEASE NOTE: California Business & Professions Code Section 801.01 (h)(3) requires every professional liability insurance carrier that submits this report to provide with the report copies of the records (including x-rays, ultrasounds, MRIs, CT scans, etc.) and depositions.

Records included ○ Yes ○ No (if not, please provide reason):

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
CENTRAL COMPLAINT UNIT
2005 Evergreen Street, Sacramento, CA 95815
(916) 263-2424
www.mbc.ca.gov

PHYSICIAN REPORTING - CRIMINAL ACTIONS

Pursuant to Section 802.1 of the California Business and Professions Code
(see reverse for specific information)

Reporting Physician Information

Name: _____ Medical License # _____
Address: _____ Phone# _____
_____ Date of Birth _____

Defense Counsel: _____ Phone# _____
Address: _____
_____
_____

INDICTMENT OR INFORMATION FILED CHARGING A FELONY

□ Indictment □ Information Filed Date Filed _____
Name/Address of Court _____ Court Case # _____
_____
_____

Violations (Code/Section/Description) _____
_____
_____
_____

CRIMINAL CONVICTIONS

□ MISDEMEANOR □ FELONY

□ JURY VERDICT □ PLEA (□ NOLO CONTENDERE/NO CONTEST; □ GUILTY)

Name/Address of Court _____ Date Filed _____
_____ Court Case # _____
_____

Violations (Code/Section/Description) _____
_____
_____
_____

SENTENCING INFORMATION Date _____
_____□ Prison or Jail - Length/Time Frame _____
_____□ Probation - Length/Time Frame _____
_____□ Special Terms/Conditions _____
_____□ Restitution - Amount _____
□ Fines/Fees - Amount _____
□ Community Service _____

Additional comments _____
_____

Section 802.1 of the California Business and Professions Code states:

(a)(1) A physician and surgeon, osteopathic physician and surgeon, and a doctor of podiatric medicine shall report either of the following to the entity that issued his or her license:

(A) The bringing of an indictment or information charging a felony against the licensee.

(B) The conviction of the licensee, including any verdict of guilty, or plea of guilty or no contest, of any felony or misdemeanor.

(2) The report required by this subdivision shall be made in writing within 30 days of the date of the bringing of the indictment or information or of the conviction.

(b) Failure to make a report required by this section shall be a public offense punishable by a fine not to exceed five thousand dollars ($5,000).

State of California Department of Consumer Affairs

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2005 Evergreen Street, Suite 1200
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www.mbc.ca.gov

REPORTING REQUIREMENTS FOR COURT CLERKS

Pursuant to Sections 803.5, 803.6 of the Business and Professions Code
(See Reverse for Synopsis)

COURT: _____ CONTACT PERSON: _____
ADDRESS: _____
_____ PHONE: _____

PHYSICIAN/PROVIDER

NAME: _____ MEDICAL LICENSE #: _____
ADDRESS: _____
_____ DATE OF BIRTH: _____
OTHER: _____
_____

JUDGMENT

Please attach a copy of the applicable court documents

DOCKET/CASE #: _____ DATE: _____
AMOUNT: _____
PLAINTIFF NAME: _____
PLAINTIFF'S ATTORNEY NAME: _____
PLAINTIFF'S ATTORNEY ADDRESS: _____
_____

CHARGED WITH A CRIME

Please attach a copy of the applicable court documents

PLEASE CHECK ONE: ☐ FELONY ☐ MISDEMEANOR
DOCKET CASE #: _____ ARRESTING AGENCY: _____
DATE OF ARREST: _____ CHARGE: _____
ADDRESS: _____
_____
COMMENTS: _____
_____

CRIMINAL CONVICTIONS

Please attach a copy of the applicable court documents

PLEASE CHECK ONE: ☐ FELONY ☐ MISDEMEANOR
DOCKET CASE #: _____ ARRESTING AGENCY: _____
DATE OF ARREST: _____ CHARGE: _____
ADDRESS: _____
_____
SENTENCE: _____
COMMENTS: _____
_____

FOR MEDICAL BOARD USE ONLY

CASE #: _____ CAS UPDATED BY: _____

The following are excerpts from the Business and Professions Code:

Reporting Requirements for Court Clerks – Judgments
803. Within 10 days after a judgment by a court of this state that a person who holds a license, certificate, or other similar authority from an agency mentioned in subdivision (a) of Section 800 (except a person licensed pursuant to Chapter 3 (commencing with Section 1200)) has committed a crime, or is liable for any death or personal injury resulting in a judgment of any amount caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services, the clerk of the court which rendered the judgment shall report that fact to the agency that issued the license, certificate, or other similar authority.

Reporting Requirement – Felony Convictions
803.5, (b) The clerk of the court in which a licensee of one of the boards is convicted of a crime shall, within 48 hours after the conviction, transmit a *certified copy* of the record of conviction to the applicable board. Where the licensee is regulated by an allied health board, the record of conviction shall be transmitted to that allied health board and the Medical Board of California.
(Amended by Stats. 1993, Ch. 1267.)

Hearing Transcripts – Probation Reports
803.6, (a) The clerk of the court shall transmit any felony preliminary hearing transcripts concerning a defendant licensee to the Medical Board of California and applicable allied health board, or the California Board of Podiatric Medicine, as applicable, where the total length of the transcript is under 800 pages and shall notify the appropriate board of any proceeding where the transcript exceeds that length.

Court Clerks may send the Medical Board any reports pertaining to licensees of the following Boards or Committees on Affiliated Healing Arts: Physician Assistant, Podiatric Medicine, Psychology, and Registered Dispensing Optician.

*****Court Clerks are also required to report similar information pertaining to licensees of the following agencies. Please contact the appropriate agency for reporting requirements.*****

California Acupuncture Board
444 N. 3rd St., Suite 260
Sacramento, CA 95811
(916) 445-3021
www.acupuncture.ca.gov

Board of Registered Nursing
1625 N. Market Blvd., Suite N-217
Sacramento, CA 95834
(916) 322-3350
www.rn.ca.gov

Hearing Aid Dispensers Bureau
1625 N. Market Blvd., Suite S-209
Sacramento, CA 95834
(916) 574-7990
www.dca.ca.gov/hearingaid

Dental Board of California
2005 Evergreen Street, Suite 1550
Sacramento, CA 95815
(916) 263-2300
www.dbc.ca.gov

California State Board of Optometry
2420 Del Paso Road, Suite 255
Sacramento, CA 95834
(916) 575-7170
www.optometry.ca.gov

Physical Therapy Board of California
2005 Evergreen Street, Suite 1350
Sacramento, CA 95815
(916) 561-8200
www.ptb.ca.gov

Osteopathic Medical Board of California
2720 Gateway Oaks Dr., Suite 350
Sacramento, CA 95833
(916) 263-3100
www.ombc.ca.gov

Board of Examiners in Veterinary Medicine
2005 Evergreen Street, Suite 2250
Sacramento, CA 95815
(916) 263-2610
www.vmb.ca.gov

Respiratory Care Board
444 N. 3rd St., Suite 270
Sacramento, CA 95814
(916) 323-9983
www.rcb.ca.gov

Board of Chiropractic Examiners
2525 Natomas Park Drive, Suite 260
Sacramento, CA 95834
(916) 263-5355
www.chiro.ca.gov

Board of Pharmacy
1625 N. Market Blvd., Suite N-219
Sacramento, CA 95834
(916) 445-5014
www.pharmacy.ca.gov

Speech-Language Pathology and Audiology Board
2005 Evergreen Street, Suite 2100
Sacramento, CA 95815
(916) 263-2666
www.slpab.ca.gov

Board of Vocational Nurse and Psychiatric Technicians
2535 Capitol Oaks Drive Suite 205
Sacramento, CA 95833
(916) 263-7800
www.bvnpt.ca.gov

Board of Behavioral Sciences
1625 N. Market Blvd., Suite S-200
Sacramento, CA 95834
(916) 574-7830
www.bbs.ca.gov

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2434 FAX (916) 263-2435
www.mbc.ca.gov

HEALTH FACILITY/PEER REVIEW REPORTING FORM
(Required by Section 805 of the California Business & Professions Code)

NOTE: Certain actions, with respect to staff privileges, membership or employment of physicians and podiatrists must be reported to the Medical Board of California when they are imposed or voluntarily accepted for a medical disciplinary cause or reason. Reports on osteopathic physicians, dentists and psychologists should be directed to their respective Boards. Please see the reverse/second page of this form for further information.

******PLEASE PRINT OR TYPE******

REPORTING ENTITY

Please check type of Reporting Entity: ○ Health Care Facility or Clinic - §805(a)(1)(A) ○ Health Care Service Plan - §805(a)(1)(B) ○ Professional Society - §805(a)(1)(C) ○ Medical Group or Employer - §805(a)(1)(D)

Name	Telephone #:
Chief Executive Officer/Medical Director/Administrator	Chief of Medical Staff
Name of person preparing report:	Telephone #
street address city state zip code	

LICENTIATE

Name (Last) (First) License #

Physician ○ Podiatrist ○

ACTION TAKEN

Date(s) of Action(s) and Duration (attached additional sheets if necessary)

Type(s) of Action(s) - Check all that apply. **CHECK HERE IF THIS IS A SUPPLEMENTAL REPORT** ☐

(a) For a medical disciplinary cause or reason:
_____ Denial/rejection of application for staff privileges
_____ Denial/rejection of application for membership
_____ Termination or revocation of staff privileges
_____ Termination or revocation of membership
_____ Termination or revocation of employment

(b) For a cumulative total of 30 days or more for any 12 month period, and for a medical disciplinary cause or reason:
_____ Restriction(s) imposed on staff privileges
_____ Restriction(s) imposed on membership
_____ Restriction(s) imposed on employment
_____ Restriction(s) voluntarily accepted on staff privileges
_____ Restriction(s) voluntarily accepted on membership
_____ Restriction(s) voluntarily accepted on employment

If staff privileges were restricted, list specific restrictions imposed or voluntarily accepted:

(c) Following notice of an impending investigation based on information indicating medical disciplinary cause or reason:
_____ Licentiate resigned from staff
_____ Licentiate resigned from membership
_____ Licentiate resigned from employment
_____ Licentiate took leave of absence from staff
_____ Licentiate took leave of absence from membership
_____ Licentiate took leave of absence from employment

(d) For a summary suspension that remains in effect for a period in excess of 14 days for a medical disciplinary cause or reason:
_____ Imposition of summary suspension on staff privileges
_____ Imposition of summary suspension on membership
_____ Imposition of summary suspension on employment

DESCRIPTION OF ACTION: Attach additional sheet(s) describing the facts and circumstances of the medical disciplinary cause or reason and any other relevant information related to the action taken, including, but not limited to, the number of cases reviewed, time frame covered, any patient deaths involved, any malpractice filings as a result of the physician's actions, any expert/peer opinions obtained, etc.

Signature Date
Chief Executive Officer/Medical Director/Administrator

Signature Date
Chief of Medical Staff

ADDITIONAL INFORMATION

To complete this form, for definition of terms, when, how, and who should report, please refer to Section 805 of the California Business and Professions Code. You may access this information via www.leginfo.ca.gov under California Law, Business and Professions Code.

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COPY TO LICENTIATE

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SUPPLEMENTAL REPORT

A supplemental report must be made within thirty (30) days following the date the Licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as corrective action by the reporting entity.

MEDICAL BOARD OF CALIFORNIA
DISCIPLINE COORDINATION UNIT
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Fax # (916) 263-2420

January 2007

The Hot Sheet - A Summary of Administrative Actions

Electronic copies of these documents are available at no cost at www.mbc.ca.gov

A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

ALLIEGRO, Anselmo Miguel, M.D.
Glendale, CA
License number: C-38447
Stipulated decision effective: 12/14/2006
Surrender of License.

CEREVKA, Joseph Michal, M.D.
Beverly Hills, CA
License number: AFE-26777
Stipulated decision effective: 12/15/2006
Surrender of License.

DEGREGORIO, Peter A., M.D.
Jacksonville, NC
License number: G-19551
Decision effective: 12/15/2006
License revoked.

DORROS, Gerald, M.D.
Wilson, WY
License number: G-54448
Public Letter of Reprimand
issued: 12/29/2006

FLORES, Pepito Lim, M.D.
Hemet, CA
License number: A-37508
Stipulated decision effective: 12/15/2006
Revoked, stayed, 5 years probation.

GRAY, Jeffrey Thomas, M.D.
Sacramento, CA
License number: G-56251
Stipulated decision effective: 12/7/2006
Surrender of License.

HOGEN, Victor S., M.D.
Northridge, CA
License number: A-13117
Stipulated decision effective: 12/31/2006
Surrender of License.

IN, George Chitam, M.D.
Los Angeles, CA
License number: A-48565
Stipulated decision effective: 4/24/2006
Public Reprimand issued: 12/4/2006

JOHNSON, Jack Wallace, M.D.
Garden Grove, CA
License number: G-21314
Stipulated decision effective: 12/15/2006
Revoked, stayed, 5 years probation.

LEE, Michele Simone, M.D.
Miramar, FL
License number: A-70423
Public Letter of Reprimand issued: 12/1/2006

SACK, Johannes Reinhard, M.D.
San Diego, CA
License number: G-48845
Stipulated decision effective: 12/29/2006
Revoked, stayed, current probation
extended 5 years.

SPENCER, Christopher Scott, M.D.
Lancaster, CA
License number: G-45684
Stipulated decision effective: 10/7/2005
Public Reprimand issued: 12/6/2006

WHITE, Jerald D., M.D.
Del Mar, CA
License number: G-9677
Decision effective: 12/29/2006
Public Reprimand issued.

Physician Assistants

BENDERT, Michael
Imperial, CA
License number: PA-14660
Decision effective: 12/14/2006
License revoked.

SHARMA, Sudha
Modesto, CA
License number: PA-12831
Stipulated decision effective: 12/4/2006
Revoked, stayed, 5 years probation.

Physical Therapists

NILES, Gail Barrie
Simi Valley, CA
License number: PT-5239
Decision effective: 12/14/2006
Public Reproval issued.

THIO, Brian
Chino Hills, CA
License number: PT-27597
Decision effective: 12/13/2006
Public Reproval issued.

Physical Therapist Assistants

MUELLER, Carla Lee
Klamath Falls, OR
License number: AT-4268
Decision effective: 12/22/2006
Public Reproval issued.

PAYROVY, Saeedeh
Agoura Hills, CA
License number: AT-2966
Decision effective: 12/13/2006
Revoked, stayed, 2 years probation.

Psychologist

YOUNG, David J. W., Ph.D.
Sebastopol, CA
License number: PSY-11593
Stipulated decision effective: 12/27/2006
Surrender of License.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

AGUILAR, Christopher, M.D.
Lodi, CA
License number: G-83131
Accusation filed: 12/19/2006

AMSDEN, Neal F., M.D.
Laguna Beach, CA
License number: A-15208
Accusation filed: 12/18/2006

ARJMANDFARD, Abdol Rassol, M.D.
Philadelphia, PA
License number: A-87931
Accusation filed: 12/1/2006

BABINE, Sarah Elizabeth, M.D.
Kennebunk, ME
License number: G-79659
Accusation filed: 12/29/2006

CARABETH, Julian, M.D.
Avila Beach, CA
License number: A-49768
Accusation filed: 12/4/2006

FERNANDO, Israel Valdez, M.D.
Bettendorf, IA
License number: A-69914
Accusation filed: 12/12/2006

GALLOWAY, Carl Anthony, M.D.
Westlake Village, CA
License number: C-35766
Petition to Revoke Probation
filed: 12/29/2006

GROSS, Joel Alan, M.D.
Lafayette, CA
License number: G-44417
Accusation filed: 12/12/2006

HINES, Demetrius Devaughn, M.D.
Oakland, CA
License number: A-75764
Accusation filed: 12/19/2006

HUFF, Michael Borchard, M.D.
Oxnard, CA
License number: A-34873
Accusation and Petition to Revoke
Probation filed: 12/19/2006

KAVEH, Natalie G., M.D.
Bell Canyon, CA
License number: A-81166
Accusation filed: 12/1/2006

KOH, Kee Seng, M.D.
Arcadia, CA
License number: A-30888
Accusation filed: 12/14/2006

LEE, James Jungmin, M.D.
Anaheim, CA
License number: G-73421
Accusation filed: 12/13/2006

LEUNG, Raymond W. P., M.D.
Pasadena, CA
License number: G-48262
Accusation filed: 12/11/2006

MARTIN, Franklin McLain, M.D.
Escondido, CA
License number: G-65456
Accusation filed: 12/14/2006

MARTIN, Roscoe Bernard, M.D.
Wilton, CA
License number: A-39017
Accusation filed: 12/12/2006

NGUYEN, Minh N., M.D.
Long Beach, CA
License number: G-59442
Accusation filed: 12/5/2006

PHAM, Co Dang Long, M.D.
Westminster, CA
License number: A-34091
Accusation filed: 12/21/2006

REISER, Jeffrey Marc, M.D.
Lincoln, CA
License number: G-32548
Accusation filed: 12/21/2006

SHIU, Tony G., M.D.
Pleasanton, CA
License number: A-55151
Accusation filed: 12/1/2006

THOMPSON, Lenardo Danny, M.D.
Pensacola, FL
License number: G-69595
Accusation filed: 12/22/2006

Physical Therapists

SCHMETZ, Karl Stephen
San Anselmo, CA
License number: PT-11351
Accusation filed: 12/21/2006

TURNER, David George
Livermore, CA
License number: PT-18170
Accusation filed: 12/5/2006

WILLIAMS, William David
Hermosa Beach, CA & Boulder, CO
License number: PT-29643
Accusation filed: 12/21/2006

Physical Therapist Assistants

ABELLA, Regie R.
Danville, CA
License number: AT-2692
Accusation filed: 12/5/2006

KENNEDY, John Joseph
San Diego, CA
License number: AT-2377
Accusation filed: 12/12/2006

KOHLEY, Stephen Richard
Loma Linda, CA
License number: AT-6368
Accusation filed: 12/20/2006

Podiatrists

HERNANDEZ, Virgil Theodore, D.P.M.
Santa Ana, CA
License number: E-3884
Accusation filed: 12/4/2006

SCIVALLY, John Wayne, D.P.M.
Walnut Creek, CA
License number: E-4319
Accusation filed: 12/5/2006

Psychologist

ROBERTS, David Curtis, Ph.D.
Oakland, CA
License number: PSY-5645
Accusation filed: 12/28/2006

ACCUSATION WITHDRAWN OR DISMISSED

Accusation "Withdrawn" means the formal charges were dropped before the matter went to an administrative hearing (often after the licensee has passed a competency examination). Accusation "Dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physician & Surgeon

PARK, Peter Hyohaeng, M.D.
Los Angeles, CA
License number: A-54976
Accusation withdrawn: 12/6/2006

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

CHAU, Patrick Kin-Yee, M.D.
Vancouver, WA
License number: G-68517
Amended Accusation filed: 12/27/2006

KARALLA, Mark H., M.D.
Los Angeles, CA
License number: AFE-39792
Amended Accusation filed: 12/6/2006

LEE, Sondra Benay, M.D.
Lancaster, CA
License number: A-71268
Amended Accusation filed: 12/1/2006

LI, Ted Yitao, M.D.
San Francisco, CA
License number: A-55348
Amended Accusation filed: 12/19/2006

MINKS, William Joseph, M.D.
Des Moines, IA
License number: C-39424
Amended Accusation filed: 12/1/2006

PADILLA, Marlon D., M.D.
Carrollton, TX
License number: G-57472
Amended Accusation filed: 12/14/2006

SHEGA, John Francis, M.D.
San Diego, CA
License number: G-40700
Amended Accusation filed: 12/1/2006

SMITH, Brenton Robert, M.D.
Riverdale, CA
License number: A-36249
Amended Accusation filed: 12/7/2006

STRUB, Irvin H., M.D.
Upland, CA
License number: C-14061
Amended Accusation filed: 12/4/2006

Podiatrist

GRAVES, Richard Henry, D.P.M.
Los Alamitos, CA
License number: E-3954
Amended Accusation filed: 12/12/2006

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician Assistant

TREBINO, Rosanne Elizabeth
Sacramento, CA
License number: PA-18795
Stipulated decision effective: 12/8/2006
5 year probationary license granted.

These are recent administrative actions. The Decisions become operative on the Effective Date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decions, which are negotiated settlements waiving court appeals.

Copies of decisions and other documents are available at no cost at www.mbc.ca.gov.

You may also send your written request, including the name and license number of the licensee, to:

Medical Board of California
Enforcement Program
Central File Room
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
DISCIPLINE COORDINATION UNIT
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Fax # (916) 263-2420

February 2007

The Hot Sheet - A Summary of Administrative Actions

Electronic copies of these documents are available at www.mbc.ca.gov

A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Board of Physical Therapy***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

AJILORE, Ebenezer Olatunde, M.D.
Pasadena, CA
License number: A-30816
Stipulated decision effective: 3/31/2005
Public Letter of Reprimand
issued: 1/23/2007

ALI, Mahmoud Ismail, M.D.
San Francisco, CA
License number: A-81127
Stipulated decision effective: 1/29/2007
Revoked, stayed, 5 years probation.

ALSTON, Adrienne Theresa, M.D.
Los Angeles, CA
License number: G-44804
Stipulated decision effective: 1/3/2007
Revoked, stayed, 5 years probation.

BARTH, Hanya, M.D.
San Francisco, CA
License number: A-31974
Stipulated decision effective: 1/16/2007
Revoked, stayed, 4 years probation.

BECERRA, Luis Ignacio, M.D.
San Diego, CA
License number: A-48520
Decision effective: 1/8/2007
Revoked, stayed, 3 years probation.

BHULLAR, Indermeet Singh, M.D.
Orlando, FL
License number: A-55423
Stipulated decision effective: 1/8/2007
Revoked, stayed, 5 years probation.

BLOCK, Jeffrey Peter, M.D.
Thousand Oaks, CA
License number: G-36760
Stipulated decision effective: 6/7/2006
Public Reprimand issued: 1/17/2007

CARABETH, Julian
Avila Beach, CA
License number: A-49768
Stipulated decision effective: 1/11/2007
Surrender of License.

DAVIDSON, Elaine Hovey, M.D.
Valley Center, CA
License number: A-55617
Stipulated decision effective: 1/29/2007
Revoked, stayed, 1 year probation.

GRANT, Marshall William, M.D.
Indio, CA
License number: A-40835
Stipulated decision effective: 1/29/2007
Public Reprimand issued.

GUIDRY, Paul Lee, Jr., M.D.
Los Angeles, CA
License number: G-73021
Stipulated decision effective: 1/29/2007
Revoked, stayed, 3 years probation with
30 days actual suspension.

HAYES, Freddie L., M.D.
Fresno, CA
License number: C-21598
Stipulated decision effective: 1/8/2007
Public Reprimand issued.

HOLLOMAN, John D.
San Luis Obispo, CA
License number: C-24131
Stipulated decision effective: 1/31/2007
Surrender of License.

JAFRI, Syed Faisal, M.D.
Leawood, KS
License number: A-72962
Public Letter of Reprimand issued: 1/24/2007

KARALLA, Mark H.
Los Angeles, CA
License number: AFE-39792
Stipulated decision effective: 1/24/2007
Surrender of License.

LANCASTER, Thomas Jerome, M.D.
Yuba City, CA
License number: G-70162
Stipulated decision effective: 1/26/2007
Revoked, stayed, 5 years probation

LAZARUS, Veronica A., M.D.
Santa Monica, CA
License number: A-43363
Stipulated decision effective: 1/5/2007
Public Reprimand issued.

LOTFY, Abdou Maged Micha
Ontario, CA
License number: A-49878
Stipulated decision effective: 1/2/2007
Surrender of License.

LOVALVO, Leonard J.
Fresno, CA
License number: A-20687
Stipulated decision effective: 1/2/2007
Surrender of License.

MAEWAL, Hrishi Kesh
Fort Worth, TX
License number: A-25648
Decision effective: 1/10/2007
License revoked.

MANSOUR, Medhat Nosshi, M.D.
Los Angeles, CA
License number: A-24055
Decision effective: 1/2/2007
Public Reprimand issued.

MARINO, James Francis, M.D.
Poway, CA
License number: G-40978
Decision effective: 1/5/2007
Revoked, stayed, 5 years probation.

MARTIN, Malverse, M.D.
West Hills, CA
License number: G-38477
Stipulated decision effective: 1/29/2007
Revoked, stayed, 5 years probation with
30 days actual suspension.

MIR, Jehan Zeb
Lynwood, CA
License number: A-24647
Decision effective: 1/5/2007
License revoked.

NEFF, Merlin Lee, Jr.
Chino Hills, CA
License number: A-19918
Stipulated decision effective: 1/12/2007
Surrender of License.

NAYYAR, Manmohan, M.D.
Apple Valley, CA
License number: A-42225
Stipulated decision effective: 1/1/2007
Revoked, stayed, 4 years probation.

ORGEL, Jeremy Eugene, M.D.
San Francisco, CA
License number: G-72591
Stipulated decision effective: 1/17/2007
Revoked, stayed, 5 years probation with 30 days actual suspension.

SORENSEN, Eric Neil, M.D.
Hanford, CA
License number: A-34991
Stipulated decision effective: 2/24/2006
Public Reprimand issued: 1/17/2007

TOBINICK, Edward Lewis, M.D.
Los Angeles, CA
License number: G-37710
Stipulated decision effective: 1/29/2007
60 days suspension, stayed, 1 year probation.

VAHID, Khosro, M.D.
Brentwood, CA
License number: A-42627
Stipulated decision effective: 1/3/2007
Revoked, stayed, 2 years probation.

WHITE, Lloyd George, M.D.
Murrieta, CA
License number: G-37804
Stipulated decision effective: 1/18/2007
Revoked, stayed, 3 years probation.

YACOBIAN, Sonia H., M.D.
Glendale, CA
License number: A-52602
Stipulated decision effective: 1/22/2007
Revoked, stayed, probation extended to 5/16/2010.

Physical Therapist

LINDLEY, Larry James
Lake Forest, CA
License number: PT-24979
Decision effective: 12/14/2007
Public Reprimand issued.

Podiatrist

AVAKIAN, Frederick, D.P.M.
Valencia, CA
License number: E-4191
Stipulated decision effective: 1/2/2007
Revoked, stayed, 2 years probation.

Psychologist

THOMPSON, Amy V., Ph.D.
San Diego, CA
License number: PSY-19296
Stipulated decision effective: 1/11/2007
Surrender of License.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

ANDERSON, Donovan John, M.D.
Mohave Valley, AZ
License number: G-48061
Accusation filed: 1/4/2007

BEHNIWAL, Mandeep J. B. S., M.D.
Granite Bay, CA
License number: A-79753
Accusation filed: 1/16/2007

BENGS, Carl M., M.D.
Oceanside, CA
License number: G-2057
Accusation filed: 1/16/2007

BLOCKER, David Clinton, M.D.
Centerville, OH
License number: G-47830
Accusation filed: 1/26/2007

COUTURE, Larry Henry, M.D.
Riverside, CA
License number: A-63843
Accusation filed: 1/26/2007

COVARRUBIAS, Gonzalo Antonio, M.D.
San Juan Capistrano, CA
License number: A-32492
Accusation filed: 1/4/2007

DECARLO, Bruce Phillip, M.D.
Long Beach, CA
License number: C-51535
Accusation filed: 1/24/2007

EVANS, Thomas Ross, M.D.
Tulare, CA
License number: G-30778
Accusation filed: 1/17/2007

GARCIA, Gilbert L., M.D.
Glendale, CA
License number: G-10939
Accusation filed: 1/24/2007

GONZALEZ, Salvador Alonso, M.D.
Fresno, CA
License number: A-60322
Accusation filed: 1/16/2007

HAZAN, Sabine Solika, M.D.
Ventura, CA
License number: C-51399
Accusation filed: 1/4/2007

JELLINEK, Lawrence Roger, M.D.
Santa Barbara, CA
License number: G-29482
Accusation filed: 12/29/2006

KOPLIN, Lawrence Mark, M.D.
Beverly Hills, CA
License number: G-35647
Accusation filed: 1/11/2007

LEE, Thomas Tuan-Tong, M.D.
Montclair, CA
License number: A-37294
Accusation filed: 1/24/2007

LOUIE, Henry Wah, M.D.
Palm Springs, CA
License number: G-62393
Accusation filed: 1/19/2007

MACMORRAN, Ian Scott, M.D.
San Diego, CA
License number: G-19401
Accusation filed: 1/17/2007

MALAYAN, Samuel Ara, M.D.
Glendale, CA
License number: G-61143
Accusation filed: 1/3/2007

MECUM, Robert Andrew, M.D.
Whittier, CA
License number: G-78258
Accusation filed: 1/26/2007

O'DONNELL, Eugene P., M.D.
Whittier, CA
License number: C-27965
Accusation and Petition to Revoke Probation filed: 1/17/2007

PANCIO, Mark, M.D.
Sacramento, CA
License number: A-91394
Accusation filed: 1/2/2007

PATEL, Jyotinkumar K., M.D.
Laguna Niguel, CA
License number: A-43752
Accusation filed: 1/11/2007

QUADRO, Robert Elton, M.D.
Sacramento, CA
License number: G-40361
Accusation filed: 1/9/2007

RAYMOND, Frederick, M.D.
Whittier, CA
License number: G-32652
Accusation filed: 1/5/2007

ROBINSON, Mark Dewayne, M.D.
Elk Grove, CA
License number: G-61971
Accusation filed: 1/4/2007

TA, Viet Duy, M.D.
Rancho Cucamonga, CA
License number: A-69957
Accusation filed: 1/26/2007

ULLOA, Fernando Gonzalo, M.D.
Mill Valley, CA
License number: G-49903
Accusation filed: 1/16/2007

VAN DOREN, John Derrick, M.D.
Murrieta, CA
License number: G-60750
Petition to Revoke Probation
filed: 1/24/2007

VARAKIAN, Lusik S., M.D.
Glendale, CA
License number: A-39856
Accusation filed: 1/4/2007

VONG, Garen T., M.D.
San Francisco, CA
License number: A-54155
Accusation filed: 1/30/2007

WARNER, Clarence Emanuel, M.D.
Sherman Oaks, CA
License number: G-62334
Petition to Revoke Probation
filed: 1/4/2007

WARSHAL, William Samuel, M.D.
San Jose, CA
License number: G-41468
Accusation filed: 1/22/2007

WIGGINS, Steven Herbst, M.D.
Sacramento, CA
License number: C-41663
Accusation filed: 1/30/2007

WINTERS, Kenneth B., M.D.
Long Beach, CA
License number: A-33139
Petition to Revoke Probation
filed: 1/3/2007

YEE, George Wendel, M.D.
Salinas, CA
License number: G-51573
Accusation filed: 1/23/2007

YURK, Robin A., M.D.
Studio City, CA
License number: G-85617
Accusation filed: 1/9/2007

Physician Assistant

HARRIS, Leonard Russell
Sacramento, CA
License number: PA-16521
Accusation filed: 1/9/2007

Physical Therapist

FROST, Jonah J.
Culver City, CA
License number: PT-32194
Accusation filed: 1/30/2007

Psychologists

KAUFMAN, Valerie, Ph.D.
Los Angeles, CA
License number: PSY-13480
Accusation filed: 1/3/2007

RIVERS, Marie Davidson, Ph.D.
Altadena, CA
License number: PSY-3603
Accusation filed: 1/2/2007

TAHMISIAN, James A., Ph.D.
Santa Maria, CA
License number: PSY-3959
Accusation filed: 1/10/2007

WINDHAM, Marilyn A., Ph.D.
Lincoln, CA
License number: PSY-18492
Accusation filed: 1/19/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

BITTER, Patrick Henry, Jr., M.D.
Los Gatos, CA
License number: G-50914
Amended Accusation filed: 1/2/2007

FRANCK, Elizabeth Reddan, M.D.
San Francisco, CA
License number: G-81779
Amended Accusation filed: 1/24/2007

GRISOLIA, James Santiago, M.D.
San Diego, CA
License number: G-42884
Amended Accusation filed: 1/31/2007

MORRIS, David Jack, M.D.
Price, UT
License number: G-28067
Amended Accusation filed: 1/19/2007

PATT, Richard Bernard, M.D.
Houston, TX
License number: A-51347
Amended Accusation filed: 1/30/2007

PHAM, Khanh Gia, M.D.
Westminster, CA
License number: A-41805
Amended Accusation filed: 1/26/2007

PLUNKETT, Patrick A., M.D.
South Pasadena, CA
License number: C-30729
Amended Accusation filed: 1/5/2007

VENTRA, Pamela Christine, M.D.
Chattanooga, TN
License number: GFE-85186
Amended Accusation filed: 1/19/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "Withdrawn" means the formal charges were dropped before the matter went to an administrative hearing (often after the licensee has passed a competency examination). Accusation "Dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

ROTH, Kenneth Edward, M.D.
Pleasanton, CA
License number: G-21304
Accusation dismissed: 1/2/2007

WADE, Jeffrey Farrell, M.D.
Torrance, CA
License number: A-61453
Accusation withdrawn: 1/9/2007

STATEMENTS OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Podiatrists

KHOSROABADY, Alireza
Woodland Hills, CA
License number: None
Statement of Issues filed: 1/26/2007

O'MEARA, Sean
Sacramento, CA
License number: None
Statement of Issues filed: 1/5/2007

Psychologists

HUDSON, Phillip
Torrance, CA
License number: None
Statement of Issues filed: 1/8/2007

LORINE, Kim-Ha N.
Los Angeles, CA
License number: None
Statement of Issues filed: 1/22/2007

STATEMENTS OF ISSUES WITHDRAWN

Physical Therapists

RAMSEY, Kimberly
Phoenix, AZ
License number: None
Statement of Issues
withdrawn: 1/9/2007

TOBIAS, Leslie Nichole
Los Angeles, CA
License number: None
Statement of Issues
withdrawn: 12/20/2007

STATEMENT OF ISSUES DECISION

Podiatrist

SALAND, Joel
Los Angeles, CA
License number: None
Decision effective: 1/2/2007
License denied.

These are recent administrative actions. The Decisions become operative on the Effective Date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decions, which are negotiated settlements waiving court appeals.

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Enforcement Program
Central File Room
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Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
DISCIPLINE COORDINATION UNIT
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Fax # (916) 263-2473

March 2007

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

ACOSTA, Emmanuel Galang, M.D.
Windermere, FL
License number: C-52000
Decision effective: 2/25/2007
Revoked, stayed, 2 years probation.

ALAVI, Munawar, M.D.
San Jose, CA
License number: A-37226
Stipulated decision effective: 9/12/2005
Public Reprimand issued: 2/27/2007

DEVIA, Alvaro Hernan, M.D.
Reno, NV
License number: C-51454
Stipulated decision effective: 2/15/2007
Public Reprimand issued.

FERRER, Carlos Busuego, M.D.
Murrieta, CA
License number: A-37236
Stipulated decision effective: 2/5/2007
Revoked, stayed, 7 years probation with 4 months actual suspension.

FLANIGAN, George Dalton, III, M.D.
Los Angeles, CA
License number: A-47749
Stipulated decision effective: 2/15/2007
Revoked, stayed, 5 years probation.

GHOSH, Bharati, M.D.
Montclair, CA
License number: A-34230
Decision effective: 2/28/2007
Revoked, stayed, 7 years probation.

GROSS, Joel Alan
Lafayette, CA
License number: G-44417
Stipulated decision effective: 2/21/2007
Surrender of License.

HATHERLEY, John Anthony, M.D.
Huntington Beach, CA
License number: G-52940
Decision effective: 2/23/2007
Revoked, stayed, 5 years probation.

KIRSHBAUM, Robert J., M.D.
Rancho Cucamonga, CA
License number: G-9868
Stipulated decision effective: 2/26/2007
Public Reprimand issued.

KRAMER, Raymond Davies
Redlands, CA
License number: G-48896
Decision effective: 2/13/2007
License revoked.

LIMPIN, Juanita E.
Sacramento, CA
License number: A-22422
Decision effective: 2/7/2007
License revoked.

MASELLY, Michael Joseph, M.D.
East Syracuse, NY
License number: C-42779
Stipulated decision effective: 2/9/2007
Revoked, stayed, 3 years probation.

O'BRIEN, Thomas Patrick
Seattle, WA
License number: C-50833
Stipulated decision effective: 2/7/2007
Surrender of License.

PETERS, Katherine Ann
Escondido, CA
License number: G-67313
Decision effective: 2/26/2007
License revoked.

SANDHU, Rajwant Singh
Roseville, CA
License number: A-41264
Stipulated decision effective: 2/21/2007
Surrender of License.

SCOTT, Leonard K.
Budapest, Hungary
License number: A-28912
Decision effective: 2/28/2007
License revoked.

TORRES-RUIZ, Cecilio
Orlando, FL
License number: A-53081
Decision effective: 2/2/2007
License revoked.

YANKOWITZ, Philip
Calabasas, CA
License number: A-28039
Stipulated decision effective: 2/2/2007
Surrender of License.

Physician Assistant

HENUBER, Sara Elizabeth
St. Augustine, FL
License number: PA-17492
Stipulated decision effective: 2/27/2007
Surrender of License.

Physical Therapist

BUMACOD, Estrelita Balitao
Bakersfield, CA
License number: PT-12164
Decision effective: 2/26/2007
Public Reprimand issued.

Podiatrist

LAI, Chun-Sun, D.P.M.
San Francisco, CA
License number: E-1996
Stipulated decision effective: 2/5/2007
Revoked, stayed, 4 years probation.

Psychologists

HIRSH, Darra, Ph.D.
Fresno, CA
License number: PSY-16504
Decision effective: 2/2/2007
Revoked, stayed, 6 years probation with 45 days actual suspension.

SMITH, Stephen Jeffrey, Ph.D.
Redlands, CA
License number: PSY-8918
Stipulated decision effective: 2/15/2007
Surrender of License.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

ALBERTS, Leonard Hillel, M.D.
Provincetown, MA
License number: G-36739
Accusation filed: 2/21/2007

CADIZ, Rolando B., M.D.
Riverside, CA
License number: A-43039
Accusation filed: 2/20/2007

COOK, Albert Paul, M.D.
Murrieta, CA
License number: A-22030
Accusation filed: 2/20/2007

DELA CRUZ, Teddy Villegas, M.D.
Beverly Hills, CA
License number: C-50232
Accusation filed: 2/20/2007

EIDELMAN, William S., M.D.
Los Angeles, CA
License number: G-32011
Accusation and Petition to Revoke Probation filed: 2/20/2007

GOLD, Lawrence Harvey Allan, M.D.
Westlake Village, CA
License number: G-61305
Accusation filed: 2/7/2007

JORDAN, Irene Ow Gleason, M.D.
Palmdale, CA
License number: A-14408
Accusation filed: 2/21/2007

KAMSON, Solomon, M.D.
Seattle, WA
License number: G-51847
Accusation filed: 2/21/2007

LEE, James Edward, M.D.
Davis, CA
License number: G-66831
Petition to Revoke Probation filed: 2/23/2007

ODEA, John Patrick Kie, M.D.
Los Angeles, CA
License number: A-32629
Accusation filed: 2/16/2007

PATEL, Atul J., M.D.
Chino Hills, CA
License number: A-71897
Accusation filed: 2/14/2007

PRAKASH, Om, M.D.
Apple Valley, CA
License number: A-39024
Accusation filed: 2/1/2007

REISBORD, David A., M.D.
Los Angeles, CA
License number: G-8913
Accusation filed: 2/21/2007

STADLER, Edward Alan, M.D.
San Clemente, CA
License number: G-23122
Accusation filed: 2/14/2007

STOCKARD, Charles Geer, Jr., M.D.
Hacienda Heights, CA
License number: C-42444
Accusation filed: 2/1/2007

WEST, Brian Robert, M.D.
Long Beach, CA
License number: G-65175
Accusation filed: 2/26/2007

WORMUTH, Thomas Michael, M.D.
Cullman, AL
License number: G-37616
Accusation filed: 2/21/2007

Physician Assistant

CATES, John Harvey
Bakersfield, CA
License number: PA-10552
Accusation filed: 2/27/2007

Podiatrist

ALVARO, Michael S., D.P.M
Los Angeles, CA
License number: E-3777
Accusation filed: 2/27/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

HOAK, Thomas C., Jr., M.D.
Ripon, CA
License number: G-79434
Amended Accusation filed: 2/9/2007

LEMUS, Julio Fernando, M.D.
Los Angeles, CA
License number: A-44494
Amended Accusation filed: 2/27/2007

NIGRO, Dennis M., M.D.
Encinitas, CA
License number: C-36972
Amended Accusation filed: 2/14/2007

WINKLER, Heidi Ann, M.D.
Norwalk, CA
License number: A-50311
Amended Accusation filed: 2/15/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "Withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "Dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

HASS, Frederick J., M.D.
San Rafael, CA
License number: C-27265
Accusation withdrawn: 2/21/2007

SHAHBAZIAN, Armen A., M.D.
Orange, CA
License number: C-37327
Accusation withdrawn: 2/28/2007

SONG, Jong Eon, M.D.
Moreno Valley, CA
License number: A-34264
Accusation dismissed: 2/8/2007

YANG, Chun Esther, M.D.
Newport Beach, CA
License number: G-83219
Accusation dismissed: 2/15/2007

Psychologist

TAHMISIAN, James A., Ph.D.
Santa Maria, CA
License number: PSY-3959
Accusation withdrawn: 2/21/2007

STATEMENT OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Psychologist

CANNEN, Larry C.
Culver City, CA
License number: None
Statement of Issues filed: 2/9/2007

STATEMENT OF ISSUES DECISION

Physical Therapist Assistant

HUGHES, Emone L.
Corte Madera, CA
License number: AT-8386
Decision effective: 2/23/2007
License granted with 3 years probation.

These are recent administrative actions. The Decisions become operative on the Effective Date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decions, which are negotiated settlements waiving court appeals.

Copies of decisions and other documents are available at no cost at www.mbc.ca.gov.

You may also send your written request, including the name and license number of the licensee, to:

Medical Board of California
Enforcement Program
Central File Room
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
DISCIPLINE COORDINATION UNIT
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Fax # (916) 263-2473

April 2007

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

AMSDEN, Neal F.
Laguna Beach, CA
License number: A-15208
Stipulated decision effective: 3/26/2007
Surrender of License.

ARON, Morris Benedict, M.D.
Templeton, CA
License number: G-20328
Decision effective: 2/7/2005
Public Reprimand issued: 3/7/2007

ASHRAF, Mohammad, M.D.
Madera, CA
License number: A-35686
Stipulated decision effective: 3/12/2007
Revoked, stayed, 35 months probation.

BORRELL, Leo James, M.D.
Houston, TX
License number: C-31240
Decision effective: 3/22/2007
Revoked, stayed, 3 years probation.

BRIGHT, Robert Clayton, Jr.
Pasadena, CA
License number: A-63567
Decision effective: 3/16/2007
License revoked.

CHAU, Patrick Kin-Yee
Vancouver, WA
License number: G-68517
Stipulated decision effective: 3/8/2007
Surrender of License.

FEDERHART, Jay Beckett, M.D.
Escondido, CA
License number: G-84686
Public Letter of Reprimand
issued: 3/30/2007.

KOMOROWSKA-TIMEK, Ewa D., M.D.
Loma Linda, CA
License number: A-77833
Public Letter of Reprimand
issued: 3/27/2007

KOTLEWSKI, George
East Amherst, NY
License number: G-31227
Stipulated decision effective: 3/28/2007
Surrender of License.

KUPFERSCHMIDT, William
Hawthorne, CA
License number: A-33537
Decision effective: 3/28/2007
License revoked.

LAWRENCE, Allen Leizerowitz, M.D.
Desert Hot Springs, CA
License number: A-22501
Stipulated decision effective: 3/12/2007
Public Reprimand issued.

LEE, Sondra Benay, M.D.
Lancaster, CA
License number: A-71268
Decision effective: 3/2/2007
Public Reprimand issued.

MACIAS, Richard Joseph, M.D.
Atascadero, CA
License number: A-42168
Stipulated decision effective: 3/30/2007
Public Reprimand issued.

MINKS, William Joseph
Des Moines, IA
License number: C-39424
Decision effective: 3/30/2007
License revoked.

MOSSER, Robert Stanley
Bakersfield, CA
License number: CFE-36586
Stipulated decision effective: 3/22/2007
Surrender of License.

SCRUGGS, Ramon, M.D.
Tustin, CA
License number: G-48978
Stipulated decision effective: 3/2/2007
Revoked, stayed, 35 months.

SHELLCROFT, John Wesley, II
Vacaville, CA
License number: G-44107
Decision effective: 3/19/2007
License revoked.

STONEFELD, Donald Frank
Rhinelander, WI
License number: G-17951
Stipulated decision effective: 3/26/2007
Surrender of License.

TEHRANI, Abolghasem M., M.D.
Los Angeles, CA
License number: A-38064
Stipulated decision effective: 3/2/2007
Revoked, stayed, 5 years probation with
6 months actual suspension.

THANOS, Jerald John, M.D.
Fullerton, CA
License number: A-46502
Stipulated decision effective: 3/19/2007
Public Reprimand issued.

YEARSLEY, Steven Gary
Saint George, UT
License number: G-84232
Stipulated deicison effective: 3/2/2007
Surrender of License.

Physical Therapists

BUSTOS, Sunny James Bautista
Visalia, CA
License number: PT-28941
Decision effective: 3/29/2007
Revoked, stayed, 3 years probation with 5 days actual suspension.

HUENNIGER, Amy Lynne
Santa Monica, CA
License number: PT-29208
Decision effective: 3/30/2007
Public Reprimand issued.

SWISHER, Donna Jean
El Cajon, CA
License number: PT-14508
Stipulated decision effective: 3/29/2007
Revoked, stayed, 5 years probation.

Physical Therapist Assistants

GALYUK, Andrew
El Sobrante, CA
License number: AT-6612
Stipulated decision effective: 3/28/2007
Revoked, stayed, 3 years probation.

KEITH, Michele Marie
Santa Rosa, CA
License number: AT-4056
Decision effective: 3/29/2007
License revoked.

TUOMAINEN, Paul Mathias
Sacramento, CA
License number: AT-4481
Decision effective: 3/8/2007
Public Reprimand issued.

Podiatrist

GRAVES, Richard Henry, D.P.M.
Los Alamitos, CA
License number: E-3954
Stipulated decision effective: 3/9/2007
Revoked, stayed, 7 years probation.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

ABELES, Ernest D., M.D.
New York, NY
License number: G-11698
Accusation filed: 3/1/2007

ALLEN, Everett Douglas, M.D.
Crescent City, CA
License number: G-54881
Accusation filed: 3/29/2007

BANKER, Deborah Ellen, M.D.
Malibu, CA
License number: G-39808
Petition to Revoke Probation filed: 3/13/2007

BERLOW, Rustin R., M.D.
La Jolla, CA
License number: G-76945
Accusation filed: 3/27/2007

CASHATT, Troy D., M.D.
Los Angeles, CA
License number: A-63013
Accusation filed: 3/14/2007

FRANK, Sidney Alan, M.D.
Visalia, CA
License number: G-23569
Accusation filed: 3/1/2007

HACK, Terrence Charles, M.D.
Ayer, MA
License number: G-50146
Accusation filed: 3/23/2007

HARRIS, Richard I., M.D.
Los Angeles, CA
License number: G-29416
Petition to Revoke Probation filed: 3/8/2007

HARTNETT, John Michael, M.D.
Mill Valley, CA
License number: G-72166
Accusation filed: 3/16/2007

HONZEL, Mark Robert, M.D.
Beverly Hills, CA
License number: A-43785
Accusation filed: 3/13/2007

JOHNSON, Eddie Glen, III, M.D.
Shreveport, LA
License number: C-50439
Accusation filed: 3/28/2007

KAHN, Robert Sylvan, M.D.
Lummi Island, WA
License number: GFE-32820
Accusation filed: 3/28/2007

KIMPLE, John Michael, M.D.
Redding, CA
License number: G-29775
Accusation filed: 3/20/2007

LOOS, Donald C., M.D.
Bakersfield, CA
License number: A-17613
Accusation filed: 3/23/2007

METROS, Kevin Lee, M.D.
Escondido, CA
License number: G-71444
Accusation filed: 3/23/2007

MOINFAR, Nader, M.D.
Longwood, FL
License number: A-64834
Accusation filed: 3/28/2007

MORIARTY, Sarah Alice, M.D.
Stockton, CA
License number: A-93218
Accusation and Petition to Revoke Probation filed: 3/29/2007

MUKERJI, Sasanka, M.D.
Napa, CA
License number: A-16848
Accusation filed: 3/22/2007

PATEL, Mitulkumar Pravinchandr, M.D.
Las Vegas, NV
License number: G-74858
Accusation filed: 3/14/2007

SCHLUSSELBERG, Martin Emanuel, M.D.
Corona, CA
License number: C-41554
Accusation filed: 3/12/2007

SMITH, Andrew James Kendrc, M.D.
Santa Monica, CA
License number: A-60393
Accusation filed: 3/28/2007

STEWART, Kerby James, M.D.
Austin, TX
License number: A-39131
Accusation and Petition to Revoke Probation filed: 3/19/2007

TRINDLE, Michael Ryan, M.D.
San Francisco, CA
License number: G-63287
Petition to Revoke Probation filed: 3/15/2007

VANSPEYBROECK, John Arthur, M.D.
Eureka, CA
License number: G-28829
Accusation filed: 3/9/2007

WATSON, Louis Herman, M.D.
Claremont, CA
License number: G-32156
Accusation filed: 3/9/2007

WILLIAMSON, George D., M.D.
Hamilton, TX
License number: C-39455
Accusation filed: 3/29/2007

ZIMMERMAN, Kimberly Rose, M.D.
Shadow Hills, CA
License number: A-45334
Accusation filed: 3/8/2007

Physical Therapists

BROWN, Scott Jeffrey
Palo Cedro, CA
License number: PT-18444
Accusation filed: 3/19/2007

DUNN, Nina Renee
Moraga, CA
License number: PT-9655
Accusation and Petition to Revoke Probation filed: 3/15/2007

FINLEY, Barbara Joan
El Dorado, CA
License number: PT-14964
Accusation filed: 3/12/2007

HERNANDEZ, Ruel Funtila
Covina, CA
License number: PT-27335
Accusation filed: 3/13/2007

Physical Therapist Assistant

RONQUILIO, Donna Kay
Redlands, CA
License number: AT-3651
Accusation filed: 3/30/2007

Psychologists

KAPPLER, Kevin Andrew, Ph.D.
Napa, CA
License number: PSY-9536
Accusation filed: 3/30/2007

PORTMAN, Sandra M., Ph.D.
San Francisco, CA
License number: PSY-13090
Accusation filed: 3/8/2007

SPINDELL, William Arden, Ph.D.
West Hills, CA
License number: PSY-4890
Accusation filed: 3/21/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

ABDALLA, Ahmad Mohamad, M.D.
Northridge, CA
License number: A-32150
Amended Accusation filed: 3/20/2007

BYRNE, Brian Anthony, M.D.
Wildomar, CA
License number: A-39837
Amended Accusation filed: 3/13/2007

O'DONNELL, Eugene P., M.D.
Whittier, CA
License number: C-27965
Amended Accusation and Petitiion to Revoke Probation filed: 3/8/2007

PETITT, John Charles, M.D.
Santa Maria, CA
License number: G-52812
Amended Accusation filed: 3/5/2007

SAGINOR, Mark L., M.D.
Marina del Rey, CA
License number: G-8242
Amended Accusation filed: 3/20/2007

SEIGLE, Richard Duboe, M.D.
Indio, CA
License number: G-45936
Amended Accusation filed: 3/23/2007

VANNIX, David Lee, M.D.
Fontana, CA
License number: G-61461
Amended Accusation filed: 3/8/2007

Physical Therapist

WRIGHT, Richard Scott
Vista, CA
License number: PT-9924
Amended Accusation filed: 3/13/2007

Psychologist

HEARD, Cynthia, Ph.D.
Redondo Beach, CA
License number: PSY-13478
Amended Accusation filed: 3/12/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "Withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "Dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

KAPLAN, Jerold Zelig, M.D.
Berkeley, CA
License number: C-37413
Accusation withdrawn: 3/7/2007

VANNIX, David Lee, M.D.
Fontana, CA
License number: G-61461
Accusation withdrawn: 3/19/2007

PROBATIONARY LICENSES

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician & Surgeon

ALCALA, Hilda Jimenez
Chicago, IL
License number: A-99618
Stipulated decision effective: 3/23/2007
3 year probationary license granted.

Physical Therapist

SIFLING, William John
Los Angeles, CA
License number: PT-33545
Decision effective: 3/1/2007
4 year probationary license issued.

STATEMENT OF ISSUES DECISIONS

Physician & Surgeon

WEISS, Gary Neal
Bakersfield, CA
License number: None
Decision effective: 3/12/2007
License denied.

Podiatrist

O'MEARA, Sean M., D.P.M.
Sacramento, CA
License number: EL-1691
Stipulated decision effective: 3/5/2007
License granted, revoked, stayed, 3 years probation.

Psychological Assistant

DOKTOR, Raymond
Santa Monica, CA
Registration number: PSB-32746
Decision effective: 3/8/2007
Registration granted.

STATEMENT OF ISSUES WITHDRAWN

Physician & Surgeon

DROUIN, Paul
Del Mar, CA
License number: None
Statement of Issues withdrawn: 3/27/2007

Psychology

PATTON, Steve W., Ph.D.
Costa Mesa, CA
License number: None
Statement of Issues withdrawn: 3/28/2007

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Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
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May 2007

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Board of Physical Therapy***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

ALAMY, Moustafa El, M.D.
Paramount, CA
License number: A-48912
Stipulated decision effective: 4/2/2007
Revoked, stayed, 4 years probation.

ANDELMAN, Robert Paul, M.D.
Portland, TX
License number: G-30552
Public Letter of Reprimand
issued: 4/11/2007

BITTER, Patrick Henry, Jr., M.D.
Los Gatos, CA
License number: G-50914
Stipulated decision effective: 4/2/2007
Revoked, stayed, 1 year probation.

BRADLEY, Cecil Arthur, M.D.
San Jose, CA
License number: C-34133
Stipulated decision effective: 4/2/2007
Revoked, stayed, 5 years probation.

CHEN, Robert Chinen-Yuan, M.D.
Las Vegas, NV
License number: A-73437
Stipulated decision effective: 4/30/2007
Public Reprimand issued.

D'AMBROSIO, Francis Gerard, M.D.
Malibu, CA
License number: G-73590
Stipulated decision effective: 4/2/2007
Revoked, stayed, 5 years probation.

GORE, Bernard Zak, M.D.
San Rafael, CA
License number: G-16401
Stipulated decision effective: 4/9/2007
Revoked, stayed, 35 months probation.

GROVEMAN, Joseph E., M.D.
Palm Springs, CA
License number: A-17870
Stipulated decision effective: 4/12/2007
Revoked, stayed, 1 year probation.

HINES, Demetrius Devaughn
Oakland, CA
License number: A-75764
Decision effective: 4/12/2007
License Revoked.

LIU, Samantha Landie
San Mateo, CA
License number: G-77884
Decision effective: 4/9/2007
License Revoked.

LUCERO, Kenneth Grant, M.D.
Blythe, CA
License number: G-60508
Stipulated decision effective: 4/23/2007
Public Reprimand issued.

MAO, Yvonne, M.D.
Los Angeles, CA
License number: A-73790
Decision effective: 4/2/2007
Revoked, stayed, 5 years probation.

MARKS, Eric Adam, M.D.
Beaumont, TX
License number: G-71565
Stipulated decision effective: 4/9/2007
Revoked, stayed, 3 years probation.

NASH, Zev-David
Montgomery, AL
License number: G-65398
Stipulated decision effective: 4/9/2007
Surrender of License.

NYAMATHI, Eswar Appa, M.D.
Northridge, CA
License number: A-40919
Stipulated decision effective: 4/9/2007
Revoked, stayed, 35 months probation.

PANCIO, Mark
Sacramento, CA
License number: A-91394
Stipulated decision effective: 4/10/2007
Surrender of License.

PEVSNER, Paul Hershel, M.D.
New York, NY
License number: G-21659
Stipulated decision effective: 4/16/2007
Revoked, stayed, 5 years probation with 2 years actual suspension.

PRINCE, Luther Terrance, III, M.D.
Minneapolis, MN
License number: G-71693
Stipulated decision effective: 4/26/2007
Revoked, stayed, 3 years probation.

REISER, Jeffrey Marc
Lincoln, CA
License number: G-32548
Stipulated decision effective: 4/3/2007
Surrender of License.

RICHTER, Ralph W.
Tulsa, OK
License number: G-4749
Stipulated decision effective: 4/25/2007
Surrender of License.

ROSENBLATT, Michael M.
Burlington, IA
License number: CFE-34153
Stipulated decision effective: 4/9/2007
Surrender of License.

ROUHE, Richard L., M.D.
Corona, CA
License number: G-12642
Stipulated decision effective: 4/26/2007
Revoked, stayed, 5 years probation.

STOLL, Seymour Martin, M.D.
Beverly Hills, CA
License number: A-35055
Stipulated decision effective: 4/2/2007
Revoked, stayed, 35 months probation.

SUN, Andrew S., M.D.
Monterey Park, CA
License number: G-13537
Stipulated decision effective: 4/30/2007
Revoked, stayed, 4 years probation.

THOMPSON, Lenardo Danny
Pensacola, FL
License number: G-69595
Decision effective: 4/27/2007
License Revoked.

VAN DOREN, John Derrick
Murrieta, CA
License number: G-60750
Decision effective: 4/30/2007
License Revoked.

VANEK, Chaim, M.D.
Portland, OR
License number: A-77368
Stipulated decision effective: 10/10/2006
Public Letter of Reprimand
issued: 4/11/2007

WILLIAMS, Richard Anthony, M.D.
San Dimas, CA
License number: A-40188
Decision effective: 4/30/2007
Public Reprimand issued.

WINTERS, Kenneth B.
Long Beach, CA
License number: A-33139
Stipulated decision effective: 4/17/2007
Surrender of License.

YURK, Robin A.
Studio City, CA
License number: G-85617
Decision effective: 4/26/2007
License Revoked.

Physician Assistants

HAMLIN, Jeffrey Michael
Burney, CA
License number: PA-16524
Stipulated decision effective: 4/23/2007
Revoked, stayed, 5 years probation.

HENDERSON, Marianne
Chico, CA
License number: PA-12641
Decision effective: 4/9/2007
License Revoked.

Physical Therapists

LITVINOFF, Lavrenti Paul
Laguna Niguel, CA
License number: PT-6710
Decision effective: 4/11/2007
License Revoked.

SCHMETZ, Karl Stephen
San Francisco, CA
License number: PT-11351
Stipulated decision effective: 4/30/2007
Public Reproval issued.

Psychologist

MAUNG, Iqbal T., Ph.D.
West Covina, CA
License number: PSY-10964
Stipulated decision effective: 4/5/2007
Revoked, stayed, 3 years probation.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

ADAMS, Jan Rudalgo, M.D.
Los Angeles, CA
License number: A-51004
Accusation filed: 4/10/2007

BADR, Mohamed Ibrahim, M.D.
Lake Elsinore, CA
License number: A-56397
Accusation filed: 4/20/2007

COSGROVE, Zachary King, M.D.
Bakersfield, CA
License number: A-70710
Accusation filed: 4/23/2007

DORSEY, Thomas Reid, M.D.
Bonita, CA
License number: G-54664
Accusation filed: 4/12/2007

DUGGAL, Arun, M.D.
Modesto, CA
License number: A-42295
Accusation filed: 4/2/2007

HSIAO, Luke I-Jen, M.D.
San Bernardino, CA
License number: A-32101
Accusation filed: 4/30/2007

KAPELEVICH, Diana L., M.D.
Los Angeles, CA
License number: A-44245
Accusation filed: 4/6/2007

LEVINE, Harvey Allan, M.D.
New York, NY
License number: G-13400
Accusation filed: 4/12/2007

MAGBANUA, Laurie Fenete, M.D.
Chatsworth, CA
License number: A-23946
Accusation filed: 4/6/2007

MODI, Jasvant N., M.D.
Los Angeles, CA
License number: A-39818
Accusation filed: 4/11/2007

PILOVETZKY, Pierre, M.D.
Burbank, CA
License number: A-52249
Accusation filed: 4/10/2007

RYLL, Erich D., M.D.
Carmichael, CA
License number: G-13357
Accusation filed: 4/6/2007

SALMASSI, Sadegh, M.D.
Delano, CA
License number: A-39604
Accusation filed: 4/3/2007

SHARP, Frank Ray, M.D.
Sacramento, CA
License number: G-30991
Accusation filed: 4/27/2007

SOROKURS, Alexander, M.D.
Marina del Rey, CA
License number: A-54193
Accusation filed: 4/16/2007

VO, Cau Van, M.D.
Westminster, CA
License number: A-43680
Accusation filed: 4/23/2007

Physician Assistants

OWER, Kristine M.
Glendora, CA
License number: PA-15583
Accusation and Petition to Revoke
Probation filed: 4/30/2007

ROLENS, Thomas A.
Springville, CA
License number: PA-12162
Accusation filed: 4/27/2007

Physical Therapists

PATEL, Sharmi
Chicago, IL
License number: PT-29370
Accusation filed: 4/10/2007

SMISER, Sylvia Maritza
Normal, IL
License number: PT-29147
Accusation filed: 4/17/2007

Podiatrists

AINSLEY, William Todd, D.P.M.
Los Angeles, CA
License number: E-4471
Accusation filed: 4/5/2007

HADDAD, Imad Ibrahim, D.P.M.
Chatsworth, CA
License number: E-3831
Accusation filed: 4/17/2007

SCIARONI, Matthew, D.P.M.
Fresno, CA
License number: E-3408
Accusation filed: 4/19/2007

Psychologist

TSOPELS, Maria, Ph.D.
Cathedral City, CA
License number: PSY-16607
Accusation filed: 4/27/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

FLORES, Byron, M.D.
Burbank, CA
License number: A-52173
Amended Accusation filed: 4/12/2007

HARTNETT, John Michael, M.D.
Mill Valley, CA
License number: G-72166
Amended Accusation filed: 4/10/2007

HUBBARD, Derrick Sidney, M.D.
Los Angeles, CA
License number: G-69055
Amended Accusation filed: 4/30/2007

KAMSON, Solomon, M.D.
Seattle, WA
License number: G-51847
Amended Accusation filed: 4/30/2007

KOLKOW, Stephen Gene, M.D.
San Diego, CA
License number: A-79480
Amended Accusation filed: 4/27/2007

PETITT, John Charles, M.D.
Santa Maria, CA
License number: G-52812
Amended Accusation filed: 4/10/2007

ACCUSATION WITHDRAWN OR DISMISSED

Accusation "Withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "Dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physician & Surgeon

KAVEH, Natalie G., M.D.
Bell Canyon, CA
License number: A-81166
Accusation withdrawn: 4/12/2007

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician & Surgeon

ROSTAMI, Babak Bobby, M.D.
Torrance, CA
License number: A-99776
Stipulated decision effective: 4/5/2007
5 year probationary license issued.

Physical Therapist

POHLKAMP, Jessica
Cincinnati, OH
License number: PT-33663
2 year probationary license issued: 4/13/2007

STATEMENT OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Psychologist

HENRY, Margaret
Los Angeles, CA
License number: None
Statement of Issues filed: 4/19/2007

STATEMENT OF ISSUES DECISION

Physician & Surgeon

HATCHER, Byron
Atascadero, CA
License number: None
Decision effective: 4/6/2007
License denied.

These are recent administrative actions. The Decisions become operative on the Effective Date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decions, which are negotiated settlements waiving court appeals.

Copies of decisions and other documents are available at www.mbc.ca.gov.

You may also send your written request, including the name and license number of the licensee, to:

Medical Board of California
Enforcement Program
Central File Room
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
DISCIPLINE COORDINATION UNIT
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Fax # (916) 263-2473

June 2007

The Hot Sheet - A Summary of Administrative Actions

Electronic copies of these documents are available at no cost at www.mbc.ca.gov

A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

BENGS, Carl M.
Oceanside, CA
License number: G-2057
Stipulated decision effective: 5/8/2007
Surrender of License.

BENZOR, Joanne Marian, M.D.
Moreno Valley, CA
License number: G-53502
Stipulated decision effective: 5/7/2007
Revoked, stayed, 5 years probation.

CALABRIA, Renato, M.D.
Beverly Hills, CA
License number: A-43041
Decision effective: 5/23/2007
Revoked, stayed, 5 years probation.

COBURN, William M., Jr.
Thousand Oaks, CA
License number: C-23131
Stipulated decision effective: 5/30/2007
Surrender of License.

COCCO, John Michael, M.D.
Valencia, CA
License number: G-18076
Decision effective: 5/21/2007
Revoked, stayed, 2 years probation.

COLLIER, Robert H., M.D.
Garden Grove, CA
License number: G-10617
Stipulated decision effective: 5/29/2007
Public Reprimand issued.

DELANO, James Edwards, Jr., M.D.
San Francisco, CA
License number: G-30580
Public Letter of Reprimand issued: 5/9/2007

GANSSLE, John Diedrich
AKA - STANLEY, John David
San Francisco, CA
License number: A-41508
Decision effective: 5/29/2007
License revoked.

GOLOB, Deborah Sue
La Jolla, CA
License number: G-69632
Stipulated decision effective: 5/4/2007
Surrender of License.

HALEVIE-GOLDMAN, Brian David, M.D.
Fairfield, CA
License number: A-38684
Decision effective: 5/16/2007
Revoked, stayed, 5 years probation with 90 days actual suspension.

HIBLER, Anita Mae, M.D.
Los Angeles, CA
License number: C-36494
Stipulated decision effective: 5/7/2007
Public Reprimand issued.

LASH, Jeffrey David
San Diego, CA
License number: A-61336
Stipulated decision effective: 5/1/2007
Surrender of License.

LAWRENCE, Larry Lester, M.D.
Lincoln, CA
License number: G-16257
Public Letter of Reprimand issued: 5/9/2007

LOAIZA, Augusto
Chattanooga, TN
License number: C-41739
Stipulated decision effective: 5/23/2007
Surrender of License.

MAGBANUA, Laurie Fenete
Chatsworth, CA
License number: A-23946
Stipulated decision effective: 5/14/2007
Surrender of License.

MARTIN, Roscoe Bernard
Wilton, CA
License number: A-39017
Decision effective: 5/31/2007
License revoked.

MITTS, Thomas Frederick, M.D.
Visalia, CA
License number: G-27736
Public Letter of Reprimand
issued: 5/22/2007

PLUNKETT, Patrick A.
South Pasadena, CA
License number: C-30729
Decision effective: 5/4/2007
Revoked, stayed, 7 years probation.

STRUB, Irvin H.
Upland, CA
License number: C-14061
Decision effective: 5/9/2007
License revoked.

WORK, William Ralph, M.D.
Fresno, CA
License number: A-66593
Public Letter of Reprimand
issued: 5/22/2007

YALE, William Scott, M.D.
Tulare, CA
License number: G-21545
Stipulated decision effective: 5/25/2007
Revoked, stayed, 2 years probation.

Podiatrist

SCIVALLY, John Wayne, D.P.M.
Walnut Creek, CA
License number: E-4319
Stipulated decision effective: 5/28/2007
Revoked, stayed, 3 years probation.

Psychologists

FIELDS, Preston Brian
Encino, CA
License number: PSY-13452
Stipulated decision effective: 5/7/2007
Surrender of License.

PORTMAN, Sandra M.
San Francisco, CA
License number: PSY-13090
Stipulated decision effective: 5/3/2007
Surrender of License.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

AGEE, Douglas Moore, M.D.
Riverside, CA
License number: A-28581
Accusation filed: 5/10/2007

ANSAR, Azber Azher, M.D.
Saint Paul, MN
License number: A-84893
Accusation filed: 5/29/2007

ATTIA, Fadia Rafla, M.D.
Corona, CA
License number: A-45954
Accusation filed: 5/11/2007

BAEZ, Alfonso M., M.D.
Gardena, CA
License number: A-35887
Accusation filed: 5/22/2007

BELLOMO, Joseph F., M.D.
Dallas, TX
License number: G-80391
Accusation filed: 5/2/2007

BERNSTEIN, Clifford Alexander, M.D.
Newport Beach, CA
License number: G-73289
Accusation filed: 5/10/2007

FLORES, Jorge N., M.D.
Hacienda Heights, CA
License number: A-33705
Accusation filed: 5/8/2007

GOLDEN, Patrick Allen, M.D.
Fresno, CA
License number: G-51665
Accusation filed: 5/16/2007

HAYES, Maria Melbourne, M.D.
East Moriches, NY
License number: G-75089
Accusation filed: 5/22/2007

JAMSHIDI, Saied, M.D.
Potomac, MD
License number: A-40445
Accusation filed: 5/16/2007

KELLY, Adrienne Moore, M.D.
San Diego, CA
License number: A-69080
Accusation filed: 5/11/2007

MEE, Steven James, M.D.
Long Beach, CA
License number: A-74290
Accusation filed: 5/11/2007

MOJARAD, Mohammad, M.D.
Rancho Mirage, CA
License number: C-42082
Accusation filed: 5/3/2007

OMIDI, Michael, M.D.
Los Angeles, CA
License number: A-84519
Accusation filed: 5/15/2007

OWEN, David C., M.D.
Torrance, CA
License number: A-17160
Accusation filed: 5/15/2007

PRAKASH, Anand, M.D.
Corona, CA
License number: A-26623
Accusation filed: 5/4/2007

QUENNEVILLE, Suzanne Marie, M.D.
San Diego, CA
License number: A-38355
Accusation filed: 5/31/2007

ROSAS, Jose Antonio, M.D.
San Francisco, CA
License number: A-72019
Accusation filed: 5/9/2007

RUBIN, Jack, M.D.
Los Alamitos, CA
License number: G-70182
Accusation filed: 5/9/2007

SHAMLOO, Jamsheed James, M.D.
Tarzana, CA
License number: A-55193
Accusation filed: 5/11/2007

SOLONIUK, Leonard Joel, M.D.
Redding, CA
License number: G-48518
Accusation filed: 5/4/2007

TATARIN, Rudiger Karl, M.D.
Orange, CA
License number: A-39779
Accusation filed: 5/9/2007

UWAYDAH, Munir, M.D.
Redondo Beach, CA
License number: A-62059
Accusation filed: 5/30/2007

WADE, Mark Robert, M.D.
Germantown, TN
License number: G-47936
Accusation and Petition to Revoke Probation filed: 5/4/2007

YEUNG, Norman Yuk Lam, M.D.
Sacramento, CA
License number: G-84409
Accusation filed: 5/16/2007

ZEGARRA, J. Peter, M.D.
Sacramento, CA
License number: G-52872
Accusation filed: 5/7/2007

Physician Assistant

NELSON, Peter William
Redondo Beach, CA
License number: PA-16082
Accusation filed: 5/22/2007

Podiatrists

CARRASCO, Pete, Jr., D.P.M.
Corona, CA
License number: E-3608
Accusation filed: 5/30/2007

SPLETTSTOESSER, James W., D.P.M.
Santa Barbara, CA
License number: E-1960
Petition to Revoke Probation filed: 5/7/2007

Midwife

MCCULLEY, Marcia Kay
Simi Valley, CA
License number: LM-134
Accusation filed: 5/8/2007

Psychologist

RAND, Randy, Ph.D.
Mill Valley, CA
License number: PSY-12137
Accusation filed: 5/31/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

AGUILAR, Christopher, M.D.
Turlock, CA
License number: G-83131
Amended Accusation filed: 5/3/2007

DONLEY-KIMBLE, Irene, M.D.
San Bernardino, CA
License number: G-42558
Amended Accusation filed: 5/17/2007

RAJARATNAM, John Namala S., M.D.
Huntington Beach, CA
License number: A-51207
Amended Accusation filed: 4/30/2007

UMANSKY, Charles, M.D.
La Jolla, CA
License number: G-9683
Amended Accusation filed: 5/11/2007

Physician Assistant

PUGLIESE, William Francis
Santa Ana, CA
License number: PA-12876
Amended Accusation filed: 5/3/2007

Psychologist

SPINDELL, William Arden, Ph.D.
West Hills, CA
License number: PSY-4890
Amended Accusatin filed: 5/31/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

BERLOW, Rustin R., M.D.
La Jolla, CA
License number: G-76945
Accusation withdrawn: 5/24/2007

GREENSPOON, Jeffrey Stuart, M.D.
Beverly Hills, CA
License number: G-41287
Accusation withdrawn: 5/11/2007

PONCE, George Armando, M.D.
Moreno Valley, CA
License number: A-51194
Accusation dismissed: 5/21/2007

STATEMENTS OF ISSUES WITHDRAWN

Physician & Surgeon

LEONG, Valerie Sze-Lynn
Loma Linda, CA
License number: None
Statement of Issues withdrawn: 5/21/2007

Physician Assistant

BOGGS, Richard
Elk Grove, CA
License number: None
Statement of Issues withdrawn: 5/8/2007

STATEMENTS OF ISSUES DECISIONS

Physician & Surgeon

WOLCOTT, William Putnam
Los Angeles, CA
License number: None
Decision effective: 5/9/2007
License denied.

Podiatrist

KHOSROABADY, Alireza, D.P.M.
Woodland Hills, CA
License number: E-4728
Stipulated decision effective: 5/16/2007
License granted, revoked, stayed, 3 years probation.

These are recent administrative actions. The decisions become operative on the effective date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decisions, which are negotiated settlements waiving court appeals.

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You may also send your written request, including the name and license number of the licensee, to:

Medical Board of California
Enforcement Program
Central File Room
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
DISCIPLINE COORDINATION UNIT
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Fax # (916) 263-2473

July 2007

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

AGUILAR, Christopher
Turlock, CA
License number: G-83131
Stipulated decision effective: 6/19/2007
Surrender of License.

BLOCKER, David Clinton
Centerville, OH
License number: G-47830
Stipulated decision effective: 6/11/2007
Surrender of License.

BRYANT, C. W., M.D.
Phoenix, AZ
License number: CFE-27901
Public Letter of Reprimand issued: 6/1/2007

GARDNER, Alan Martin
Defiance, OH
License number: G-48230
Decision effective: 6/11/2007
License revoked.

HELSTON, Raymond Herbert, M.D.
Bakersfield, CA
License number: A-23548
Stipulated decision effective: 6/6/2007
Revoked, stayed, 6 years probation with 15 days actual suspension.

HOAK, Thomas C., Jr., M.D.
Ripon, CA
License number: G-79434
Stipulated decision effective: 6/1/2007
Public reprimand issued.

JELLINEK, Lawrence Roger
Santa Barbara, CA
License number: G-29482
Stipulated decision effective: 6/28/2007
Surrender of License.

JOHNSON, Eddie Glen, III
Shreveport, LA
License number: C-50439
Stipulated decision effective: 6/28/2007
Surrender of License.

JONES, Aaron Wilson, M.D.
Redding, CA
License number: A-80253
Stipulated decision effective: 6/1/2007
Revoked, stayed, 5 years probation.

LEW, Barry Gerald
Long Beach, CA
License number: G-34168
Decision effective: 6/11/2007
License revoked.

LIFSCHUTZ, Harry, M.D.
Indio, CA
License number: G-42802
Stipulated decision effective: 6/4/2007
Revoked, stayed, 5 years probation.

MALIK, Michael Yusef Abdul, M.D.
Los Angeles, CA
License number: A-69726
Stipulated decision effective: 6/22/2007
Revoked, stayed, 5 years probation and suspended until 7/9/2007

MCMANUS, Jeffrey Craig, M.D.
Ojai, CA
License number: G-56160
Stipulated decision effective: 6/15/2007
Revoked, stayed, 5 years probation.

MOGHTADER, Mehran, M.D.
Los Angeles, CA
License number: A-62032
Stipulated decision effective: 6/8/2007
Revoked, stayed, 3 years probation.

MOON, Chae Hyun
Redding, CA
License number: A-32120
Decision effective: 6/8/2007
License revoked.

MOSEMAN, James Michael, M.D.
San Diego, CA
License number: G-68447
Stipulated decision effective: 6/22/2007
Public Reprimand issued.

NITTI, Gary Joseph, M.D.
Calabasas, CA
License number: G-49747
Stipulated decision effective: 11/28/2005
Public Letter of Reprimand issued: 6/14/2007

O'DONNELL, Eugene P., M.D.
Whittier, CA
License number: C-27965
Stipulated decision effective: 6/30/2007
Revoked, stayed, 5 years probation commencing on 3/31/2005.

PASUHUK, Edwin Hubert, M.D.
Highland, CA
License number: A-39666
Stipulated decision effective: 6/7/2007
Revoked, stayed, 5 years probation with 45 days actual suspension.

SHANTHARAM, Sanagaram S., M.D.
Fresno, CA
License number: A-52010
Public Letter of Reprimand issued: 6/8/2007

STARKS, D'Mitri, M.D.
Montclair, CA
License number: G-49823
Stipulated decision effective: 6/22/2007
Revoked, stayed, 35 months probation.

SWENSON, Michael Robert
Louisville, KY
License number: G-51605
Stipulated decision effective: 6/26/2007
Surrender of License.

VAN METER, Lawrence Richard, M.D.
Huntington Beach, CA
License number: A-26072
Public Letter of Reprimand issued: 6/14/2007

VERBY, Harry D., M.D.
San Mateo, CA
License number: G-13395
Public Letter of Reprimand issued: 6/19/2007

VONG, Garen T., M.D.
San Francisco, CA
License number: A-54155
Stipulated decision effective: 6/3/2007
Revoked, stayed, 5 years probation.

WILSON, Edward K., M.D.
Los Angeles, CA
License number: A-21304
Decision effective: 6/04/2007
Revoked, stayed, 5 years probation.

ZIMMERMAN, Marc Herbert, M.D.
Lake Havasu City, AZ
License number: G-44606
Public Letter of Reprimand
issued: 6/8/2007

Physical Therapist

SWAN, Jean Marie
Benicia, CA
License number: PT-9262
Stipulated decision effective: 6/30/2007
License revoked.

Physical Therapist Assistant

FRANKLIN, Paul Warren
Canyon Country, CA
License number: AT-4340
Stipulated decision effective: 6/6/2007
License revoked.

Psychologists

PRUITT, Joseph Henry, Jr., Ph.D.
Los Angeles, CA
License number: PSY-4089
Stipulated decision effective: 6/15/2007
Revoked, stayed, 3 years probation.

RODIGER, Georgiana, G., Ph.D.
Altadena, CA
License number: PSY-8072
Stipulated decision effective: 6/15/2007
Revoked, stayed, 5 years probation.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

BRODERICK, David Michael, M.D.
Sacramento, CA
License number: C-42099
Accusation filed: 6/15/2007

CRAGEN, Richard Darin, M.D.
Temecula, CA
License number: A-54872
Accusation filed: 6/19/2007

DYKES, John R., II, M.D.
Grand Blanc, MI
License number: G-87794
Accusation filed: 6/11/2007

ENO, Gary Ross, M.D.
Berkeley, CA
License number: A-24709
Accusation filed: 6/1/2007

HOWARD, Degrasia Anne, M.D.
Bakersfield, CA
License number: G-49333
Accusation filed: 6/15/2007

KALINA, Mark Evan, M.D.
Del Mar, CA
License number: A-49274
Accusation filed: 6/11/2007

KWONG, Myron S., M.D.
San Jose, CA
License number: A-86563
Accusation filed: 6/22/2007

LEE, Tan Shin, M.D.
Rowland Heights, CA
License number: A-50001
Accusation filed: 6/28/2007

LESSLER, Paul A., M.D.
Newport Beach, CA
License number: G-11583
Accusation filed: 6/27/2007

MCNEMAR, Thomas Bradley, M.D.
Tracy, CA
License number: G-85212
Accusation filed: 6/14/2007

MOORE, Caroline Ruth, M.D.
Yucca Valley, CA
License number: G-19522
Accusation filed: 6/8/2007

SKOGERSON, Kent Edward, M.D.
Carson City, NV
License number: A-39437
Accusation filed: 6/6/2007

VANMEURS, Dirk Hendrik, M.D.
Albany, CA
License number: G-40574
Accusation filed: 6/21/2007

WANG, Taishine, M.D.
South Gate, CA
License number: A-42340
Accusation filed: 6/1/2007

YERMIAN, John-Paul R., M.D.
Van Nuys, CA
License number: A-42042
Accusation filed: 6/22/2007

ZWASS, Josef Benjamin, M.D.
Carlsbad, CA
License number: G-62469
Accusation filed: 6/12/2007

Physician Assistant

KOEHLER, Pamela Rae
Fort Bragg, CA
License number: PA-13556
Accusation and Petition to Revoke
Probation filed: 6/19/2007

Podiatrist

TRUONG, Vinncente H.G., D.P.M.
San Jose, CA
License number: E-4177
Accusation filed: 6/18/2007

Psychologist

COYNE, Paul D., Ph.D.
Encinitas, CA
License number: PSY-7144
Accusation filed: 6/6/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

CHER, John B., M.D.
Santa Monica, CA
License number: A-38966
Amended Accusation and Petition to Revoke
Probation filed: 6/12/2007

CHIU, John Chih, M.D.
Newbury Park, CA
License number: C-31784
Amended Accusation filed: 6/22/2007

MAZAHERI, Morton Reza, M.D.
Los Angeles, CA
License number: A-30149
Amended Accusation filed: 5/29/2007

MITCHELL, Thomas Evans, Jr., M.D.
Pasadena, CA
License number: G-54207
Amended Accusation filed: 6/14/2007

NOUSHKAM, Mohammad Bagher, M.D.
Hawaiian Gardens, CA
License number: A-45935
Amended Accusation filed: 6/4/2007

SANDERS, Edward Wayne, Jr., M.D.
Sausalito, CA
License number: C-29998
Amended Accusation filed: 6/12/2007

UMANSKY, Charles, M.D.
La Jolla, CA
License number: G-9683
Amended Accusation filed: 6/28/2007

Podiatrist

SCIARONI, Matthew, D.P.M.
Fresno, CA
License number: E-3408
Amended Accusation filed: 6/27/2007

ACCUSATION WITHDRAWN OR DISMISSED

Accusation "withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physician & Surgeon

GOLD, Lawrence Harvey Allan, M.D.
Westlake Village, CA
License number: G-61305
Accusation withdrawn: 6/8/2007

STATEMENTS OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Psychologists

FIMIANI, Bret
Alameda, CA
License number: None
Statement of Issues filed: 6/4/2007

PAGE, Kathryn
Sonoma, CA
License number: None
Statement of Issues filed: 6/19/2007

STATEMENT OF ISSUES DECISION

Physician & Surgeon

SIMMONDS, John O'Neil, M.D.
Los Angeles, CA
License number: A-100364
Decision effective: 6/4/2007
License granted.

These are recent administrative actions. The decisions become operative on the effective date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decisions, which are negotiated settlements waiving court appeals.

Copies of decisions and other documents are available at no costs at www.mbc.ca.gov.

You may also send your written request, including the name and license number of the licensee, to:

Medical Board of California
Enforcement Program
Central File Room
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
DISCIPLINE COORDINATION UNIT
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Fax # (916) 263-2473

August 2007

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

ABDALLA, Ahmad Mohamad, M.D.
Northridge, CA
License number: A-32150
Stipulated decision effective: 7/19/2007
Public Reprimand issued.

ABELES, Ernest D.
New York, NY
License number: G-11698
Decision effective: 7/16/2007
License revoked.

ALBERTS, Leonard Hillel
Provincetown, MA
License number: G-36739
Decision effective: 7/11/2007
License revoked.

ARJMANDFARD, Abdol Rassol
Philadelphia, PA
License number: A-87931
Decision effective: 7/19/2007
License revoked.

BABINE, Sarah Elizabeth
Kennebunk, ME
License number: G-79659
Decision effective: 7/16/2007
License revoked.

CHOPRA, Rakesh, M.D.
Riverside, CA
License number: A-40049
Stipulated decision effective: 7/11/2007
Public Reprimand issued.

GOMEZ, Nicolas Pedaza, M.D.
Chula Vista, CA
License number: AFE-37700
Stipulated decision effective: 7/18/2007
Revoked, stayed, 5 years probation with 90 days actual suspension.

HUANG, Benjamin E., M.D.
Irvine, CA
License number: G-85607
Stipulated decision effective: 7/23/2007
Revoked, stayed, 35 months probation.

KAHN, Robert Sylvan
Lummi Island, WA
License number: GFE-32820
Stipulated decision effective: 7/5/2007
Surrender of License.

MASON, Kenneth Everett, M.D.
Huntington Beach, CA
License number: G-53438
Stipulated decision effective: 7/12/2007
Revoked, stayed, 35 months probation.

MOINFAR, Nader, M.D.
Longwood, FL
License number: A-64834
Stipulated decision effective: 7/5/2007
Public Reprimand issued.

NASHED, Adel Abdelmalsk, M.D.
Huntington Beach, CA
License number: AFE-30739
Stipulated decision effective: 7/6/2007
Public Reprimand issued.

PATEL, Mitulkumar Pravinchandr
Las Vegas, NV
License number: G-74858
Stipulated decision effective: 7/19/2007
Surrender of License.

PATEL, Ramesh R.
Fontana, CA
License number: A-40485
Stipulated decision effective: 7/3/2007
Surrender of License.

PEARSON, Gail Lee
Quincy, CA
License number: G-84398
Decision effective: 7/27/2007
License revoked.

ROBINSON, Mark Dewayne, M.D.
Elk Grove, CA
License number: G-61971
Stipulated decision effective: 7/23/2007
Revoked, stayed, 5 years probation.

SHIU, Tony G.
Pleasanton, CA
License number: A-55151
Decision effective: 7/30/2007
License revoked.

TAN, Bienvenido, M.D.
Newhall, CA
License number: A-18536
Decision effective: 7/5/2007
Public Reprimand issued.

VENTRA, Pamela Christine
Chattanooga, TN
License number: GFE-85186
Decision effective: 7/2/2007
License revoked.

WASHINGTON, Patricia A., M.D.
Coto De Caza, CA
License number: A-43579
Decision effective: 7/16/2007
Revoked, stayed, 3 years probation.

Physician Assistants

CATES, John Harvey
Bakersfield, CA
License number: PA-10552
Stipulated decision effective: 7/11/2007
Public Reprimand issued.

ROLENS, Thomas A.
Springville, CA
License number: PA-12162
Stipulated decision effective: 7/3/2007
Surrender of License.

Physical Therapists

CHARLET, David
Los Angeles, CA
License number: PT-20035
Stipulated decision effective: 7/11/2007
Revoked, stayed, 3 years probation.

GARCIA, Julie Ann
Rowland Heights, CA
License number: PT-28232
Stipulated decision effective: 7/1/2007
Revoked, stayed, 7 years probation with 90 days actual suspension.

Physical Therapist Assistants

FIX, Natalie Ann
Ventura, CA
License number: AT-5768
Stipulated decision effective: 7/11/2007
Revoked, stayed, 3 years probation.

GARCIA, Julie Ann
Rowland Heights, CA
License number: AT-3661
Stipulated decision effective: 7/1/2007
Revoked, stayed, 7 years probation with 90 days actual suspension.

Psychologists

RIVERS, Marie Davidson, Ph.D.
Altadena, CA
License number: PSY-3603
Decision effective: 7/9/2007
License revoked.

ZAMUDIO, Biatriz, Ph.D.
Van Nuys, CA
License number: PSY-11096
Decision effective: 7/2/2007
License revoked.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

BARARSANI, Mohammad, M.D.
Manhattan Beach, CA
License number: A-35392
Accusation filed: 7/26/2007

CAMPBELL, Elizabeth Trupin, M.D.
Walnut Creek, CA
License number: A-40036
Accusation filed: 7/2/2007

DOANE, Gregory Cameron, M.D.
Santa Clarita, CA
License number: G-79473
Accusation filed: 7/16/2007

FISCH, Richard, M.D.
Palo Alto, CA
License number: G-4454
Accusation filed: 7/27/2007

HUGHES, Derek Patrick, M.D.
Sacramento, CA
License number: A-61410
Accusation and Petition to Revoke Probation filed: 7/2/2007

JOHNSON, Gary Ronald, M.D.
San Andreas, CA
License number: G-27755
Accusation filed: 7/10/2007

KERWIN, David Sylvester, M.D.
Modesto, CA
License number: G-7547
Accusation filed: 7/11/2007

KNOST, Patrick Michael, M.D.
Placerville, CA
License number: G-85499
Accusation filed: 7/31/2007

KROUPA, Vladimir, M.D.
Porterville, CA
License number: A-48466
Accusation filed: 7/5/2007

LACHMAN, Norman J., M.D.
Los Angeles, CA
License number: G-15903
Accusation filed: 7/13/2007

LEW, Stephanie Fay, M.D.
Dallas, TX
License number: A-89146
Accusation filed: 7/19/2007

LOREN, Leonard M., M.D.
Sherman Oaks, CA
License number: C-23374
Accusation filed: 7/16/2007

LOUIS-JACQUES, Carline, M.D.
Torrance, CA
License number: G-86204
Accusation filed: 7/11/2007

LOYA, Rene Daniel, M.D.
Bonita, CA
License number: A-38377
Accusation filed: 7/23/2007

LUNG, Roy Chi Wing, M.D.
Torrance, CA
License number: A-53998
Accusation filed: 7/5/2007

MALKOFF, Lori L., M.D.
Encinitas, CA
License number: G-57705
Accusation filed: 7/13/2007

MICHALSKI, Michael H., Jr., M.D.
La Mesa, CA
License number: G-86189
Accusation filed: 7/5/2007

MOAYED, Ali, M.D.
Los Gatos, CA
License number: G-84380
Accusation filed: 7/31/2007

NAIK, Ramdas Beeranna, M.D.
Milpitas, CA
License number: A-32981
Accusation filed: 7/18/2007

PIRNAZAR, Cyrus, M.D.
Los Angeles, CA
License number: A-22671
Accusation filed: 7/31/2007

RASTEGAR, John Hassan, M.D.
aka RASTEGAR-FARD, Hassan, M.D.
Los Angeles, CA
License number: A-53847
Accusation filed: 7/12/2007

ROBBINS, Paul C., M.D.
Santa Clara, CA
License number: G-9189
Accusation filed: 7/20/2007

SENGELMANN, Robert Paul, M.D.
Canoga Park, CA
License number: G-16979
Accusation filed: 7/13/2007

SONG, Jong Eon, M.D.
Moreno Valley, CA
License number: A-34264
Accusation filed: 7/25/2007

STERNER, Robert Fulton, M.D.
San Diego, CA
License number: G-51708
Accusation filed: 7/31/2007

TATE, Harold Austin, M.D.
Las Vegas, NV
License number: G-74583
Accusation filed: 7/26/2007

Physician Assistants

ACEVEDO-SCHOUPS, Antonia A.
Monterey, CA
License number: PA-13324
Accusation filed: 7/31/2007

MENDOZA, Elvira Chu
Fair Oaks Ranch, CA
License number: PA-17736
Accusation filed: 7/16/2007

PAYNE, Keith Tyler
Fallbrook, CA
License number: PA-14225
Accusation filed: 7/31/2007

Physical Therapist

MARZOCCHETTI, Ezequiel Alfredo
Palmdale, CA
License number: PT-26241
Accusation filed: 7/6/2007

Psychologists

COFFEY, Dennis Alexander, Ph.D.
Los Angeles, CA
License number: PSY-12892
Accusation filed: 7/5/2007

LINDSAY, Michael A., Ph.D.
San Diego, CA
License number: PSY-13870
Accusation filed: 7/27/2007

SELLS, Christine, Ph.D.
Surfside, CA
License number: PSY-14808
Accusation filed: 7/5/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

CRAGEN, Richard Darin, M.D.
Temecula, CA
License number: A-54872
Amended Accusation filed: 7/5/2007

ELATTAR, Osamah Amin, M.D.
Los Angeles, CA
License number: A-26314
Amended Accusation filed: 7/12/2007

OMIDI, C. Julian, M.D.
Los Angeles, CA
License number: A-71181
Amended Accusation filed: 7/12/2007

VANSPEYBROECK, John Arthur, M.D.
Eureka, CA
License number: G-28829
Amended Accusation filed: 7/6/2007

WEST, Brian Robert, M.D.
Long Beach, CA
License number: G-65175
Amended Accusation filed: 7/24/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

ANYAJI, George Ifeanyichukw, M.D.
San Diego, CA
License number: A-49073
Accusation withdrawn: 7/6/2007

BANKER, Deborah Ellen, M.D.
Malibu, CA
License number: G-39808
Petition to Revoke Probation
withdrawn: 7/23/2007

BASFORD, Richard L., M.D.
Mokelumne Hill, CA
License number: G-14642
Accusation withdrawn: 7/31/2007

KOPLIN, Lawrence Mark, M.D.
Beverly Hills, CA
License number: G-35647
Accusation withdrawn: 7/24/2007

LEE, James Jungmin, M.D.
Anaheim, CA
License number: G-73421
Accusation dismissed: 7/20/2007

WARSHAL, William Samuel, M.D.
San Jose, CA
License number: G-41468
Accusation withdrawn: 7/31/2007

Podiatrist

ELWOOD, Timothy Oren, D.P.M.
Los Angeles, CA
License number: E-3789
Accusation & Petition to Revoke
Probation withdrawn: 7/16/2007

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician & Surgeon

CONRAD, Benjamin Eric, M.D.
Laguna Beach, CA
License number: A-100928
Decision effective: 7/5/2007
3 year probationary license
issued: 7/25/2007

STATEMENTS OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Physicians & Surgeons

CASTELLANOS, Andrew John
Cerritos, CA
License number: None
Statement of Issues filed: 7/17/2007

YAZDANSHENAS, Amir Reza
San Juan Capistrano, CA
License number: None
Statement of Issues filed: 7/31/2007

Psychologist

DAVIS, Bobby J.
Sacramento, CA
License number: None
Statement of Issues filed: 7/23/2007

STATEMENT OF ISSUES DECISIONS

Physicians & Surgeons

LAKNER, George Stephen
Washington, DC
License number: None
Decision effective: 7/2/2007
License denied.

WALKER, Gregory Trent
Bellflower, CA
License number: None
Decision effective: 7/12/2007
License denied.

Physician Assistant

FERGUSON, Leonard J.
San Ramon, CA
License number: None
Decision effective: 7/30/2007
License denied.

Psychologist

HUDSON, Phillip, Ph.D.
Torrance, CA
License number: Not yet issued
Stipulated decision effective: 7/2/2007
License granted, revoked, stayed, 3 years probation.

Psychological Assistant

CANNEN, Larry C., Ph.D.
Los Angeles, CA
License number: PSB-32927
Stipulated decision effective: 7/2/2007
License granted, revoked, stayed, 3 years probation.

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September 2007

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- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

AGUILERA, Manuel Chua, M.D.
Los Angeles, CA
License number: A-38823
Stipulated decision effective: 3/29/2006
Public Reprimand issued: 8/16/2007

BELLOMO, Joseph F.
Dallas, TX
License number: G-80391
Stipulated decision effective: 8/17/2007
Surrender of License.

BIMSTON, David Noel, M.D.
Davie, FL
License number: G-85112
Stipulated decision effective: 1/8/2007
Public Reprimand issued: 8/2/2007

BRAR, Harinder S., M.D.
Milledgeville, GA
License number: G-85511
Stipulated decision effective: 1/29/2007
Public Reprimand issued: 8/28/2007

BROWN, Terrill Eugene, M.D.
Visalia, CA
License number: G-53967
Stipulated decision effective: 11/9/2000
Public Reprimand issued: 8/23/2007

BUTCHER, Michael Dane, M.D.
Los Gatos, CA
License number: C-31760
Stipulated decision effective: 12/15/2006
Public Reprimand issued: 8/24/2007

DE, Malabika
Irvine, CA
License number: A-69859
Decision effective: 8/16/2007
License revoked.

DENKER, Mark Stefan, M.D.
Boca Raton, FL
License number: A-50791
Stipulated decision effective: 8/16/2007
Revoked, stayed, 5 years probation.

FRANK, Sidney Alan, M.D.
Visalia, CA
License number: G-23569
Stipulated decision effective: 8/30/2007
Revoked, stayed, 5 years probation.

GIL, Alejandro Esteban, M.D.
Los Angeles, CA
License number: A-37558
Stipulated decision effective: 8/27/2007
Revoked, stayed, 5 years probation with 30 days actual suspension.

GONZALEZ, Salvador Alonso, M.D.
Fresno, CA
License number: A-60322
Stipulated decision effective: 8/4/2007
Revoked, stayed, 3 years probation.

GUERRA, Robert Marcial, M.D.
Lompoc, CA
License number: G-65335
Stipulated decision effective: 2/5/2007
Public Reprimand issued: 8/24/2007

HOLLANDER, Neil, M.D.
Huntington Beach, CA
License number: G-18418
Stipulated decision effective: 8/15/2007
Probation extended 2 years.

HUBBARD, Derrick Sidney
Los Angeles, CA
License number: G-69055
Stipulated decision effective: 8/22/2007
Surrender of License.

HUFF, Michael Borchard
Oxnard, CA
License number: A-34873
Decision effective: 8/1/2007
License revoked.

IBRAHIM, Albeer I., M.D.
Encino, CA
License number: A-44213
Stipulated decision effective: 8/27/2007
Revoked, stayed, 5 years probation with 6 months actual suspension, stayed pending conditions.

LEE, Ken K., M.D.
Simi Valley, CA
License number: A-26661
Stipulated decision effective: 6/13/2005
Public Letter of Reprimand
issued: 8/29/2007

LEMAY, Daniel Robert, M.D.
Downey, CA
License number: G-74285
Decision effective: 8/13/2007
Public Reprimand issued.

LIZARRAGA, Juan Fernando, M.D.
Cerritos, CA
License number: A-49181
Stipulated decision effective: 8/15/2007
Probation extended 2 years.

MACMORRAN, Ian Scott, M.D.
San Diego, CA
License number: G-19401
Stipulated decision effective: 8/27/2007
Public Reprimand issued.

MAGRANN, John J.
Cypress, CA
License number: A-28610
Stipulated decision effective: 8/30/2007
Surrender of License.

NIGRO, Dennis M., M.D.
Encinitas, CA
License number: C-36972
Decision effective: 8/9/2007
Revoked, stayed, 7 years probation.

POURAT, Bijan, M.D.
Beverly Hills, CA
License number: A-33770
Stipulated decision effective: 8/24/2007
Public Letter of Reprimand issued.

ROWLAND, Dale Wilson, M.D.
San Luis Obispo, CA
License number: G-28599
Stipulated decision effective: 12/28/2006
Public Reprimand issued: 8/28/2007

SABRI, Mazin Qassim, M.D.
Montclair, CA
License number: A-35229
Stipulated decision effective: 8/16/2007
Revoked, stayed, 5 years probation.

SARSHAD, Ramin, M.D.
Culver City, CA
License number: G-79730
Stipulated decision effective: 10/11/2005
Public Reprimand issued: 8/20/2007

STEWART, Kerby James
Austin, TX
License number: A-39131
Stipulated decision effective: 8/21/2007
Surrender of License.

THEIN, Aung Myint, M.D.
Big Spring, TX
License number: A-64782
Public Letter of Reprimand
issued: 8/20/2007

TRINDLE, Michael Ryan
San Francisco, CA
License number: G-63287
Stipulated decision effective: 8/2/2007
Surrender of License.

ULLOA, Fernando Gonzalo, M.D.
Mill Valley, CA
License number: G-49903
Stipulated decision effective: 8/30/2007
Public Reprimand issued.

WIGGINS, Steven Herbst
Sacramento, CA
License number: C-41663
Decision effective: 8/24/2007
License revoked.

WILLIAMS, Wydell Lawrence, M.D.
Las Vegas, NV
License number: G-68780
Public Letter of Reprimand
issued: 8/30/2007

WILLIAMSON, George D., M.D.
Hamilton, TX
License number: C-39455
Stipulated decision effective: 7/28/2007
Public Reprimand issued: 8/28/2007

Physician Assistant

GIANNINI, John Russell
Colton, CA
License number: PA-20771
Decision effective: 8/17/2007
Revoked, stayed, 7 years probation.

Psychologists

WINDHAM, Marilyn A., Ph.D.
Lincoln, CA
License number: PSY-18492
Decision effective: 8/8/2007
License revoked.

PHELPS, Harrison Stephens, Jr., Ph.D.
Laguna Hills, CA
License number: PSY-7792
Stipulated decision effective: 8/31/2007
Surrender of License.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

BLUM, Mitchell Edward H., M.D.
Carmichael, CA
License number: G-25010
Accusation filed: 8/28/2007

DIANA, Laura E., M.D.
Watsonville, CA
License number: G-75508
Accusation filed: 8/28/2007

GAMBLE, Robert Clifton, M.D.
Clovis, CA
License number: C-42796
Accusation filed: 8/27/2007

HAKHAMIMI, Kamron Kenneth, M.D.
Studio City, CA
License number: A-74169
Accusation filed: 8/13/2007

MAGRANN, John J., M.D.
Cypress, CA
License number: A-28610
Accusation filed: 8/15/2007

MANZINI, Joseph Anthony, M.D.
Newport Coast, CA
License number: G-62860
Accusation filed: 8/17/2007

SALLEROLI, Christian Mark, M.D.
West Hollywood, CA
License number: AFE-55029
Accusation filed: 8/29/2007

SHIMA, Gary James, M.D.
San Marcos, CA
License number: G-14742
Accusation filed: 8/15/2007

TAKASUGI, Scott T., M.D.
Sacramento, CA
License number: A-43093
Accusation filed: 8/29/2007

VALLEJO, Arthur, M.D.
West Covina, CA
License number: G-64836
Accusation and Petition to Revoke
Probation filed: 8/28/2007

Physician Assistants

ANENE, Alexander C.
Cerritos, CA
License number: PA-15910
Accusation filed: 8/9/2007

LISTER, Christopher Henry, Sr.
Victorville, CA
License number: PA-14614
Accusation filed: 8/28/2007

Physical Therapists

MOTOYOSHI, Mitsumaro
Folsom, CA
License number: PT-26300
Accusation filed: 8/17/2007

SAVAHELT, Jane Elizabeth
Reseda, CA
License number: PT-9186
Petition to Revoke Probation filed: 8/29/2007

Physical Therapist Assistant

BAILES, Robert Earl
Lancaster, CA
License number: AT-262
Accusation filed: 8/29/2007

Psychologist

MARQUIS, John N., Ph.D.
Los Altos, CA
License number: PSY-2714
Accusation filed: 8/24/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

DICKERSON, Charles Howard, M.D.
Streator, IL
License number: G-41769
Amended Accusation filed: 5/23/2007

HONZEL, Mark Robert, M.D.
Beverly Hills, CA
License number: A-43785
Amended Accusation filed: 8/27/2007

IZHAR, Mohammed, M.D.
Alta Loma, CA
License number: A-30009
Amended Accusation filed: 8/22/2007

JOHNSON, Gary Ronald, M.D.
San Andreas, CA
License number: G-27755
Amended Accusation filed: 8/24/2007

KUGEL, Samuel, M.D.
National City, CA
License number: A-54412
Amended Accusation filed: 7/24/2007

MURPHY, Douglas Peter, M.D.
Morro Bay, CA
License number: A-65282
Amended Accusation filed: 8/23/2007

PATT, Richard Bernard, M.D.
Houston, TX
License number: A-51347
Amended Accusation filed: 8/30/2007

WINKLER, Heidi Ann, M.D.
Norwalk, CA
License number: A-50311
Amended Accusation filed: 8/1/2007

Midwife

MCCULLEY, Marcia Kay
Simi Valley, CA
License number: LM-134
Amended Accusation filed: 8/28/2007

Physical Therapist

WRIGHT, Richard Scott
Vista, CA
License number: PT-9924
Amended Accusation filed: 8/22/2007

Psychologist

SELLS, Christine, Ph.D.
Surfside, CA
License number: PSY-14808
Amended Accusation filed: 8/9/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

BADR, Mohamed Ibrahim, M.D.
Lake Elsinore, CA
License number: A-56397
Accusation dismissed: 8/30/2007

PATEL, Atul J., M.D.
Chino Hills, CA
License number: A-71897
Accusation withdrawn: 8/27/2007

WORMUTH, Thomas Michael, M.D.
Cullman, AL
License number: G-37616
Accusation withdrawn: 8/30/2007

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician & Surgeon

TRAN, Vincent, M.D.
Bakersfield, CA
License number: A-101551
Stipulated decision effective: 8/10/2007
3 year probationary license
issued: 9/12/2007

STATEMENT OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Physician & Surgeon

KEUNG, Yi-Kong
Clemmons, NC
License number: None
Statement of Issues filed: 8/14/2007

STATEMENT OF ISSUES DECISIONS

Psychologist Assistants

FIMIANI, Bret J.
San Francisco, CA
License number: PSB-33004
Stipulated decision effective: 8/24/2007
License granted, revoked, stayed, 5 years probation.

LORINE, Kim-Ha N.
Los Angeles, CA
License number: Not yet issued
Decision effective: 8/30/2007
License granted, revoked, stayed, 5 years probation.

These are recent administrative actions. The decisions become operative on the effective date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decisions, which are negotiated settlements waiving court appeals.

Copies of decisions and other documents are available at no cost at www.mbc.ca.gov.

You may also send your written request, including the name and license number of the licensee, to:

Medical Board of California
Enforcement Program
Central File Room
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
DISCIPLINE COORDINATION UNIT
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
Fax # (916) 263-2473

October 2007

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

BRENNAN, H. George, M.D.
Newport Beach, CA
License number: C-27484
Decision effective: 9/26/2007
Revoked, stayed, 3 years probation.

DAVID, Anna Maria, M.D.
National City, CA
License number: A-61522
Stipulated decision effective: 9/10/2007
Public Reprimand issued.

DEPINTO, Vincent James, M.D.
Colorado Springs, CO
License number: G-86735
Public Letter of Reprimand issued: 9/7/2007

EDWARDS, Hannibal
Apple Valley, CA
License number: GFE-44813
Stipulated decision effective: 9/14/2007
Surrender of License.

ELATTAR, Osamah Amin, M.D.
Los Angeles, CA
License number: A-26314
Stipulated decision effective: 9/17/2007
Public Letter of Reprimand issued.

EVANS, Thomas Ross, M.D.
Tulare, CA
License number: G-30778
Stipulated decision effective: 9/17/2007
Revoked, stayed, 5 years probation.

FERNANDO, Israel Valdez
Bettendorf, IA
License number: A-69914
Stipulated decision effective: 9/14/2007
Surrender of License.

FLORES, Cristina Salazar, M.D.
Chula Vista, CA
License number: A-54112
Stipulated decision effective: 9/10/2007
Public Reprimand issued.

HAZAN, Sabine Solika, M.D.
Ventura, CA
License number: C-51399
Stipulated decision effective: 9/12/2007
Public Reprimand issued.

HERRMANN, Donald William, M.D.
Victorville, CA
License number: G-34040
Stipulated decision effective: 9/10/2007
Additional six months added to existing probation.

HORNE, Jonathan H., M.D.
Salt Lake City, UT
License number: G-60499
Public Letter of Reprimand issued: 9/20/2007

JONES, Henry Eugene, M.D.
Oakdale, CA
License number: C-29697
Decision effective: 9/20/2007
Revoked, stayed, 5 years probation.

KAMSON, Solomon, M.D.
Seattle, WA
License number: G-51847
Stipulated decision effective: 9/26/2007
Revoked, stayed, 3 years probation.

KATIBY, Naim Safiullah, M.D.
San Leandro, CA
License number: A-50826
Stipulated decision effective: 9/26/2007
Revoked, stayed, 35 months probation.

KIMPLE, John Michael, M.D.
Redding, CA
License number: G-29775
Stipulated decision effective: 9/27/2007
Revoked, stayed, 35 months probation.

KIPPER, David A., M.D.
Beverly Hills, CA
License number: G-29776
Stipulated decision effective: 9/5/2007
Public Reprimand issued.

KUGEL, Samuel, M.D.
National City, CA
License number: A-54412
Stipulated decision effective: 9/28/2007
Public Reprimand issued.

LAMANTIA, Michele Alexandria, M.D.
El Cajon, CA
License number: G-71855
Stipulated decision effective: 9/12/2007
Public Reprimand issued.

LEDERGERBER, Walter Joseph, M.D.
Laguna Niguel, CA
License number: A-32530
Stipulated decision effective: 9/4/2007
Revoked, stayed, 7 years probation.

LEVINE, Harvey Allan, M.D.
New York, NY
License number: G-13400
Stipulated decision effective: 9/10/2007
Revoked, stayed, 5 years probation.

LI, Ted Yitao, M.D.
San Fancisco, CA
License number: A-55348
Stipulated decision effective: 6/25/2007
Public Reprimand issued: 9/6/2007

LOVELACE, Stewart W., M.D.
Manhattan Beach, CA
License number: C-30263
Decision effective: 9/28/2007
Revoked, stayed, 3 years probation.

MBAGWU, Chidozie Constance, M.D.
Riverside, CA
License number: A-51399
Stipulated decision effective: 9/4/2007
Revoked, stayed, 2 years probation.

NG, Chi Kwong, M.D.
Crystal River, FL
License number: A-53864
Public Letter of Reprimand
issued: 9/7/2007

O'NEIL, Kelly James, M.D.
Temecula, CA
License number: A-36888
Stipulated decision effective: 9/3/2007
Revoked, stayed, 35 months probation.

PEHLEVANIAN, Garo Z., M.D.
Los Angeles, CA
License number: A-38617
Decision effective: 9/24/2007
Revoked, stayed, 3 years probation.

RECINE, Carl Albert, M.D.
Coeur D' Alene, ID
License number: G-87933
Public Letter of Reprimand
issued: 9/17/2007

SCOTT, Joseph Austin, M.D.
Coral Gables, FL
License number: G-73141
Public Letter of Reprimand
issued: 9/7/2007

SHEGA, John Francis, M.D.
San Diego, CA
License number: G-40700
Decision effective: 9/27/2007
Public Reprimand issued.

STYLES, Roger Allen, M.D.
Hollywood, FL
License number: G-59795
Public Letter of Reprimand
issued: 9/7/2007

TZENG, Thomas Show-Tzer, M.D.
Whittier, CA
License number: A-37994
Decision effective: 9/14/2007
Revoked, stayed, 5 years probation.

WINGFIELD, Thomas Whetsell, M.D.
Gastonia, NC
License number: G-14490
Public Letter of Reprimand
issued: 9/7/2007

Physical Therapist

BROWN, Scott Jeffrey
Palo Cedro, CA
License number: PT-18444
Stipulated decision effective: 9/13/2007
Revoked, stayed, 5 years probation with
5 days actual suspension.

Physical Therapist Assistant

ESCOBAR, Lucia
Folsom, CA
License number: AT-1232
Stipulated decision effective: 9/17/2007
Revoked, stayed, 3 years probation.

Podiatrist

MOY, Richard Raymond, D.P.M.
Lake Forest, CA
License number: E-3833
Stipulated decision effective: 9/1/2007
Revoked, stayed, 8 years probation with
30 days actual suspension.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

ADRIAN, Adrian, M.D.
Las Vegas, NV
License number: AFE-56237
Accusation filed: 9/7/2007

AMINI, Shamim, M.D.
Oxnard, CA
License number: A-96250
Accusation filed: 9/11/2007

APUSEN, Marilou Marcos, M.D.
Los Angeles, CA
License number: AFE-36928
Accusation filed: 9/7/2007

BARCKLAY, Karen Beth, M.D.
Walnut Creek, CA
License number: A-69028
Accusation filed: 9/26/2007

BERGER, Michael Dean, M.D.
Valley Center, CA
License number: G-21264
Accusation filed: 9/12/2007

BLIKIAN, Anahit H., M.D.
Los Angeles, CA
License number: A-39608
Accusation filed: 9/13/2007

BOYAJIAN, John Arthur, M.D.
Boise, ID
License number: A-25855
Accusation filed: 9/13/2007

BROWN, James Robert, M.D.
Rancho Cucamonga, CA
License number: A-51937
Accusation filed: 9/13/2007

CURLEY, Michael Patrick, M.D.
Murrieta, CA
License number: A-45008
Accusation filed: 9/26/2007

DADA, Festus Bamidele, M.D.
Corona, CA
License number: A-40801
Accusation and Petition to Revoke
Probation filed: 9/27/2007

DANIEL, Thomas Alan, M.D.
Sacramento, CA
License number: G-53590
Accusation filed: 9/6/2007

FERRARO, Lucia M., M.D.
Huntington Beach, CA
License number: A-44810
Accusation filed: 9/11/2007

GARRISON, Thomas Edwin, M.D.
Ogden, UT
License number: C-50929
Accusation filed: 9/6/2007

GILLESPIE, Thomas Miller, M.D.
San Francisco, CA
License number: A-84706
Accusation filed: 9/26/2007

HARRON, Raymond A., M.D.
Bridgeport, WV
License number: G-8415
Accusation filed: 9/18/2007

HART, Cheryle Ram, M.D.
Spokane Valley, WA
License number: G-87598
Accusation filed: 9/11/2007

HERIC, Thomas M., M.D.
Malibu, CA
License number: A-22944
Accusation filed: 9/26/2007

INGRAM, Alice Michelle, M.D.
Crockett, TX
License number: A-65769
Accusation filed: 9/18/2007

JOHNSON, Gilbert E., M.D.
Idabel, OK
License number: CFE-29408
Accusation filed: 9/25/2007

KWOLEK, Marilyn Sue, M.D.
Danville, CA
License number: C-41932
Accusation filed: 9/11/2007

MANZO, Richard O., M.D.
La Habra, CA
License number: C-21941
Accusation filed: 9/26/2007

MARIK, Jaroslav Jan, M.D.
Beverly Hills, CA
License number: A-23697
Accusation filed: 9/12/2007

MEHRIZI, Nasser, M.D.
Paramount, CA
License number: A-48610
Accusation filed: 9/27/2007

MITTENDORFF, William John, M.D.
San Diego, CA
License number: G-44222
Accusation filed: 9/27/2007

MORA, William Edward, M.D.
Phoenix, AZ
License number: G-53726
Accusation filed: 9/27/2007

NORMAN, Michael John, M.D.
Redlands, CA
License number: G-45780
Accusation filed: 9/25/2007

RICHMOND, Harvey Sheldon, M.D.
Beverly Hills, CA
License number: C-40026
Accusation filed: 9/11/2007

SAFARI C., Hamid Reza, M.D.
Fresno, CA
License number: A-53849
Accusation filed: 9/28/2007

SHIU, Gertrude, M.D.
Sacramento, CA
License number: A-60012
Accusation filed: 9/7/2007

SILVER, Daniel Mark, M.D.
Encino, CA
License number: C-31379
Accusation filed: 9/13/2007

TOLLETTE, Armond T., Jr., M.D.
Inglewood, CA
License number: G-50837
Accusation filed: 9/21/2007

UDANI, Mahendra C., M.D.
Redondo Beach, CA
License number: A-35682
Accusation filed: 9/11/2007

VARGA, Clayton Alexander, M.D.
Pasadena, CA
License number: G-52859
Accusation filed: 9/26/2007

WINSCOTT, Mary Michelle, M.D.
Tucson, AZ
License number: A-81979
Accusation filed: 9/18/2007

Physical Therapist

SCHILLING, Erin Maria
Culver City, CA
License number: PT-25459
Accusation filed: 9//7/2007

Psychologist

LAMBERT, Scott W., Ph.D.
North Hollywood, CA
License number: PSY-12547
Accusation and Petition to Revoke
Probation filed: 9/5/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

GRISOLIA, James Santiago, M.D.
San Diego, CA
License number: G-42884
Amended Accusation filed: 9/11/2007

HABBESTAD, Robert, M.D.
Los Angeles, CA
License number: A-35077
Amended Accusation filed: 9/13/2007

LOWE, Isaac Edwin, M.D.
Oxnard, CA
License number: G-55370
Amended Accusation filed: 9/6/2007

MAZAHERI, Morton Reza, M.D.
Los Angeles, CA
License number: A-30149
Amended Accusation filed: 9/28/2007

RESNICK, Lawrence Harold, M.D.
Santa Monica, CA
License number: G-16871
Amended Accusation filed: 9/5/2007

Physical Therapist

BIANCHI, Dennis Edward
La Mesa, CA
License number: PT-10168
Amended Accusation filed: 9/6/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

IZHAR, Mohammed, M.D.
Alta Loma, CA
License number: A-30009
Accusation withdrawn: 9/13/2007

MCNEMAR, Thomas Bradley, M.D.
Tracy, CA
License number: G-85212
Accusation withdrawn: 9/5/2007

PROBATIONARY LICENSES

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician & Surgeon

BURWICK, Richard M., M.D.
Manhattan Beach, CA
License number: A-101683
Stiplated decision effective: 9/26/2007
3 year probationary license
issued: 10/3/2007

Physician Assistant

OGBODO, Emmanuel O.
Moreno Valley, CA
License number:PA-19357
Stipulated decision effective: 9/12/2007
3 year probationary license
issued: 9/20/2007

STATEMENT OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Spectacle & Contact Lens Dispenser

DAHLENE, Cindy Ann
Homeland, CA
License number: None
Statement of Issues filed: 9/13/2007

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November 2007

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

BULLIAS, Bruce Alan, M.D.
Murrieta, CA
License number: G-27217
Stipulated decision effective: 10/29/2007
Revoked, stayed, 3 years probation.

CARLTON, Lynn Norman, M.D.
Springfield, MO
License number: G-26817
Public Letter of Reprimand
issued: 10/29/2007

COOTS, Lawrence Ernest, M.D.
Orange Park, FL
License number: G-40413
Public Letter of Reprimand
issued: 10/15/2007

DICKERSON, Charles Howard
Streator, IL
License number: G-41769
Decision effective: 10/29/2007
License revoked.

DJORDJEVIC, Borko, M.D.
Palm Desert, CA
License number: A-31228
Stipulated decision effective: 10/8/2007
Revoked, stayed, 7 years probation with
3 months actual suspension.

DONALDSON, Brian Robert, M.D.
Healdsburg, CA
License number: G-32428
Decision effective: 10/8/2007
Revoked, stayed, 5 years probation.

DORSEY, Thomas Reid
Bonita, CA
License number: G-54664
Stipulated decision effective: 10/26/2007
Surrender of License.

FISCHBEIN, Stuart James, M.D.
Los Angeles, CA
License number: G-52027
Decision effective: 10/10/2007
Revoked, stayed, 7 years probation.

FLEISS, Paul M., M.D.
Los Angeles, CA
License number: A-28858
Stipulated decision effective: 10/8/2007
Revoked, stayed, 35 months probation.

FLEMING, Susan Brindamour, M.D.
Tucson, AZ
License number: G-34801
Public Letter of Reprimand
issued: 10/17/2007

FOOTE, Ronald Hope, M.D.
Las Vegas, NV
License number: G-66195
Stipulated decision effective: 10/12/2007
Revoked, stayed, 5 years probation.

FRANCK, Elizabeth Reddan
San Francisco, CA
License number: G-81779
Stipulated decision effective: 10/12/2007
Revoked, stayed, 7 years parobation, 1 year
actual suspension.
License revoked: 10/17/2007

JAHANPANAH, Fereshteh, M.D.
El Cajon, CA
License number: G-65104
Stipulated decision effective: 10/29/2007
Public Reprimand issued.

KHAN, Shagufta Parvin, M.D.
San Diego, CA
License number: A-29867
Stipulated decision effective: 10/24/2007
Revoked, stayed, additional 7 years added
to existing probation.

KOLKOW, Stephen Gene
San Diego, CA
License number: A-79480
Stipulated decision effective: 10/24/2007
Surrender of License.

KUNDEL, David Gus
Emmetsburg, IA
License number: C-30019
Stipulated decision effective: 10/3/2007
Surrender of License.

LEE, Thomas Tuan-Tong, M.D.
Montclair, CA
License number: A-37294
Stipulated decision effective: 10/25/2007
Public Reprimand issued.

LUNDAHL, Gerald Dale, M.D.
Chino Hills, CA
License number: A-28772
Stipulated decision effective: 10/26/2007
Revoked, stayed, 3 years probation.

MALKOFF, Lori L.
Encinitas, CA
License number: G-57705
Stipulated decision effective: 10/25/2007
Surrender of License.

MCLAUGHLIN, Barbara Elaine, M.D.
Paradise, CA
License number: G-13975
Stipulated decision effective: 4/16/2007
Public Reprimand issued: 10/24/2007

MOAYED, Ali
Los Gatos, CA
License number: G-84380
Stipulated decision effective: 10/22/2007
Surrender of License.

MOORE, Caroline Ruth
Yucca Valley, CA
License number: G-19522
Stipulated decision effective: 10/24/2007
Surrender of License.

OMIDI, Julian
Los Angeles, CA
License number: A-71181
Decision effective: 10/26/2007
License revoked.

PETITT, John Charles, M.D.
Santa Maria, CA
License number: G-52812
Decision effective: 10/18/2007
Revoked, stayed, 3 years probation.

PILOVETZKY, Pierre
Burbank, CA
License number: A-52249
Decision effective: 10/24/2007
License revoked.

RODIBAUGH, David Leonard, M.D.
Santa Ana, CA
License number: C-33122
Stipulated decision effective: 10/19/2007
Public Reprimand issued.

SANDERS, Edward Wayne, Jr.
Sausalito, CA
License number: C-29998
Stipulated decision effective: 10/4/2007
Surrender of License.

SCHWARTZ, George Robert
Santa Fe, NM
License number: G-23732
Stipulated decision effective: 10/24/2007
Surrender of License.

SEE, Darryl Matthew
Buena Park, CA
License number: G-61569
Stipulated decision effective: 10/30/2007
Surrender of License.

SHARP, Frank Ray
Sacramento, CA
License number: G-30991
Stipulated decision effective: 10/19/2007
Surrender of License.

STOCKARD, Charles Geer, Jr., M.D.
Hacienda Heights, CA
License number: C-42444
Stipulated decision effective: 10/4/2007
Revoked, stayed, 4 years probation.

UMANSKY, Charles, M.D.
La Jolla, CA
License number: G-9683
Stipulated decision effective: 10/25/2007
Revoked, stayed, 3 years probation.

VANMEURS, Dirk Hendrik, M.D.
Albany, CA
License number: G-40574
Stipulated decision effective: 10/15/2007
Revoked, stayed, 5 years probation.

WEISS, Justin Fredric, M.D.
Tucson, AZ
License number: G-44085
Stipulated decision effective: 2/9/2007
Public Reprimand issued: 10/11/2007

WRIGHT, Jamey D., M.D.
Spring, TX
License number: A-78435
Public Letter of Reprimand
issued: 10/11/2007

ZANDER, Alla, M.D.
Laguna Hills, CA
License number: A-61985
Stipulated decision effective: 10/26/2007
Revoked, stayed, 7 years probation.

Physician Assistant

ORTIZ, Juanita
Imperial Beach, CA
License number: PA-12947
Stipulated decision effective: 10/1/2007
Revoked, stayed, 7 years probation.

Physical Therapists

FINLEY, Barbara Joan
El Dorado Hills, CA
License number: PT-14964
Stipulated decision effective: 10/8/2007
Revoked, stayed, 5 years probation.

SHIPLEY, John Steven
Cottage Grove, OR
License number: PT-17354
Decision effective: 10/15/2007
Public Reprimand issued.

SMISER, Sylvia Maritza
Normal, IL
License number: PT-29147
Decision effective: 10/29/2007
Public Reprimand issued.

TAN, Peter
Vallejo, CA
License number: PT-21149
Stipulated decision effective: 10/30/2007
Revoked, stayed, 3 years probation.

Physical Therapist Assistant

KOHLEY, Stephen Richard
Loma Linda, CA
License number: AT-6368
Stipulated decision effective: 10/1/2007
Surrender of License.

Podiatrist

AINSLEY, William Todd, D.P.M.
Los Angeles, CA
License number: E-4471
Stipulated decision effective: 10/18/2007
Revoked, stayed, 5 years probation.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

ALLEN, John Warner, M.D.
El Cajon, CA
License number: C-37706
Accusation filed: 10/10/2007

BAHNA, Mamdouh Sadek, M.D.
Los Angeles, CA
License number: A-26744
Accusation filed: 10/29/2007

BORCHERS, Doyle John, III, M.D.
Stanford, CA
License number: A-64879
Accusation filed: 10/23/2007

COULSON, Alan Stewart, M.D.
Hamlet, NC
License number: A-25297
Accusation filed: 10/24/2007

DERICKS, Gerard Henry, Jr., M.D.
Concord, CA
License number: G-28626
Accusation filed: 10/23/2007

DHUGGA, Gurpreet Singh, M.D.
Fairfield, CA
License number: A-63219
Accusation filed: 10/12/2007

DUNN, James Sandidge, Jr., M.D.
Porterville, CA
License number: A-84568
Accusation filed: 10/16/2007

EM, Makkalearn, M.D.
Salem, OR
License number: AFE-63746
Accusation filed: 10/29/2007

GIANCHANDANI, Sanjay Sunder, M.D.
Laguna Niguel, CA
License number: G-74989
Accusation filed: 10/10/2007

HONG, Gregory Kijong, M.D.
Los Angeles, CA
License number: A-53990
Accusation filed: 10/22/2007

KEYTE, Jeffrey Jay, M.D.
Lemoore, CA
License number: A-88834
Accusation filed: 10/30/2007

MADRID, William L., M.D.
Lakewood, CA
License number: A-48312
Accusation filed: 10/5/2007

MILGRIM, Franklin Curtis, M.D.
Beverly Hills, CA
License number: G-26189
Accusation filed: 10/24/2007

MURRAY, David Bardwell, M.D.
Whittier, CA
License number: A-21805
Accusation filed: 10/4/2007

RAJAGOPAL, Usha, M.D.
San Francisco, CA
License number: A-53230
Accusation filed: 10/10/2007

RHEINSCHILD, Gary W., M.D.
Huntington Beach, CA
License number: G-13342
Accusation filed: 10/10/2007

ROGER, Vincent David, M.D.
San Diego, CA
License number: G-18625
Accusation filed: 10/10/2007

ROY, William Joseph, Jr., M.D.
Bakersfield, CA
License number: G-85889
Accusation filed: 10/23/2007

SACK, Johannes Reinhard, M.D.
San Diego, CA
License number: G-48845
Accusation and Petition to Revoke Probation filed: 10/30/2007

SCHAFER, Jeffry B., M.D.
Coronado, CA
License number: G-36897
Accusation filed: 10/23/2007

SHAW, David Graeme, M.D.
Los Altos, CA
License number: G-47925
Accusation filed: 10/5/2007

SURA, Anjana Sailesh, M.D.
Montebello, CA
License number: A-30390
Accusation filed: 10/31/2007

TAHILRAMANEY, Mona P., M.D.
Torrance, CA
License number: A-38363
Accusation filed: 10/10/2007

VOGT, Walter Arnold, M.D.
San Jose, CA
License number: G-87134
Accusation filed: 10/23/2007

Physician Assistants

COLEMAN, John Lee
Yucca Valley, CA
License number: PA-13693
Accusation filed: 10/11/2007

DUNCAN, Mark Allen
Temecula, CA
License number: PA-13002
Accusation filed: 10/17/2007

MARSHALL, Augustin Enoch
Tucson, AZ
License number: PA-17793
Accusation filed: 10/23/2007

Physical Therapist

YAZDANI, Azita
Long Beach, CA
License number: PT-28345
Accusation filed: 10/16/2007

Podiatrist

CATLEY, Mark Florentino, D.P.M.
Anaheim Hills, CA
License number: E-4352
Accusation filed: 10/23/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

ARCHIE, Carol Louise, M.D.
Los Angeles, CA
License number: G-60046
Amended Accusations filed: 10/25/2007 and 10/31/2007

ASLAN, Muzaffer, M.D.
Los Angeles, CA
License number: A-18999
Amended Accusation filed: 10/23/2007

GOLDEN, Patrick Allen, M.D.
Fresno, CA
License number: G-51665
Amended Accusation filed: 10/10/2007

KNOST, Patrick Michael, M.D.
Placerville, CA
License number: G-85499
Amended Accusation filed: 10/30/2007

OURIAN, Simon, S., M.D.
Beverly Hills, CA
License number: A-65201
Amended Accusation filed: 10/11/2007

SHAMLOO, Jamsheed James, M.D.
Tarzana, CA
License number: A-55193
Amended Accusation filed: 9/24/2007

SULEIMAN, Mustafa Ismail, M.D.
Whittier, CA
License number: A-48051
Amended Accusations filed: 10/23/2007 and 10/29/2007

Psychologist

FOOTE, Janis Elaine, Ph.D.
Los Alamitos, CA
License number: PSY-5810
Amended Accusation filed: 10/17/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

COORAY, Dilrukshie Vishanthri, M.D.
Torrance, CA
License number: A-80659
Accusation withdrawn: 10/15/2007

LEGGS, Toni Elizabeth, M.D.
Rialto, CA
License number: A-30833
Accusation withdrawn: 10/3/2007

MAHESHWARI, Bitthal Das, M.D.
Corona, CA
License number: A-26380
Accusation dismissed: 10/18/2007

MARTIN, Franklin McLain, M.D.
Escondido, CA
License number: G-65456
Accusation withdrawn: 10/15/2007

NGUYEN, Minh N., M.D.
Long Beach, CA
License number: G-59442
Accusation dismissed: 10/19/2007

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician Assistant

DAVIS, Rodney Eugene
Los Angeles, CA
License number: PA-19449
Stipulated decision effective: 10/26/2007
3 year probationary license
issued: 10/30/2007

These are recent administrative actions. The decisions become operative on the effective date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decisions, which are negotiated settlements waiving court appeals.

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You may also send your written request, including the name and license number of the licensee, to:

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DISCIPLINE COORDINATION UNIT
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Fax # (916) 263-2473

December 2007

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

BAEZ, Alfonso M., M.D.
Gardena, CA
License number: A-35887
Stipulated decision effective: 11/13/2007
1 additional year added to existing probation.

BLUM, Mitchell Edward H., M.D.
Carmichael, CA
License number: G-25010
Stipulated decision effective: 11/21/2007
Public Reprimand issued.

FEIND, Carl R., M.D.
Lafayette, IN
License number: G-54716
Public Letter of Reprimand issued: 11/6/2007

HARRIS, Richard I.
Los Angeles, CA
License number: G-29416
Decision effective: 11/26/2007
License revoked.

HUGHES, Derek Patrick, M.D.
Yuba City, CA
License number: A-61410
Stipulated decision effective: 11/19/2007
Revoked, stayed, 3 additional years added to existing probation.

JAMSHIDI, Saied, M.D.
Potomac, MD
License number: A-40445
Stipulated decision effective: 11/5/2007
Revoked, stayed, 2 years probation.

LEE, James Edward
Davis, CA
License number: G-66831
Decision effective: 11/8/2007
License revoked.

LEW, Stephanie Fay
Dallas, TX
License number: A-89146
Decision effective: 11/26/2007
License revoked.

LOWE, Isaac Edwin, M.D.
Oxnard, CA
License number: G-55370
Stipulated decision effective: 11/26/2007
Public Reprimand issued.

MOON, Young Ja
Crossville, TN
License number: A-50468
Decision effective: 11/5/2007
License revoked.

MORIARTY, Sarah Alice, M.D.
Stockton, CA
License number: A-93218
Stipulated decision effective: 11/5/2007
Revoked, stayed, 5 years probation.

MURPHY, Douglas Peter, M.D.
Morro Bay, CA
License number: A-65282
Stipulated decision effective: 11/5/2007
Revoked, stayed, 5 years probation.

PATT, Richard Bernard
Houston, TX
License number: A-51347
Stipulated decision effective: 11/5/2007
Surrender of License.

PRAKASH, Om, M.D.
Apple Valley, CA
License number: A-39024
Stipulated decision effective: 11/2/2007
Revoked, stayed, 18 months probation.

RAYMOND, Frederick, M.D.
Pasadena, CA
License number: G-32652
Decision effective: 11/16/2007
Revoked, stayed, 5 years probation.

RYLL, Erich D.
Carmichael, CA
License number: G-13357
Stipulated decision effective: 11/16/2007
Surrender of License.

SCHWARTZ, Alan
Agoura Hills, CA
License number: G-18347
Decision effective: 11/23/2007
License revoked.

SKOGERSON, Kent Edward, M.D.
Wofford Heights, CA
License number: A-39437
Stipulated decision effective: 11/16/2007
Public Reprimand issued.

SURI, Rajesh Sam, M.D.
Fremont, CA
License number: A-50486
Stipulated decision effective: 11/14/2007
Revoked, stayed, 5 years probation.

VARAKIAN, Lusik S., M.D.
Glendale, CA
License number: A-39856
Stipulated decision effective: 11/1/2007
Revoked, stayed, 7 years probation.

VITKOVA, Miluse, M.D.
Santa Clara, CA
License number: C-50745
Public Letter of Reprimand issued: 11/19/2007

Licensed Midwife

MCCULLEY, Marcia Kay
Simi Valley, CA
License number: LM-134
Stipulated decision effective: 11/14/2007
Surrender of License.

Physical Therapists

LAM, Jeffrey
San Francisco, CA
License number: PT-27810
Stipulated decision effective: 11/30/2007
Revoked, stayed, 3 years probation.

PATEL, Sharmi
Montebello, CA
License number: PT-29370
Stipulated decision effective: 11/30/2007
Public Reprimand issued.

POHLKAMP, Jessica
Cincinnati, OH
License number: PT-33663
Stipulated decision effective: 11/30/2007
Modifying terms of initial probationary license.

Podiatrist

HADDAD, Imad Ibrahim, D.P.M.
Chatsworth, CA
License number: E-3831
Stipulated decision effective: 11/16/2007
Revoked, stayed, 5 years probation with 30 days actual suspension.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

AHDOOT, Roben Dan, M.D.
Los Angeles, CA
License number: A-62395
Accusation filed: 11/15/2007

BOHEE, Sumner T., M.D.
Los Angeles, CA
License number: C-17942
Accusation filed: 11/29/2007

GANDY, Juanita, M.D.
Salinas, Ca
License number: G-55002
Accusation filed: 11/6/2007

GESCUK, Bryan Douglas, M.D.
Redwood City, CA
License number: A-65762
Accusation filed: 11/7/2007

JENKINS, Elizabeth Ann, M.D.
Woodland Hills, CA
License number: A-95751
Accusation filed: 11/27/2007

JONES, Charles Ferdinand, II, M.D.
Los Angeles, CA
License number: A-46217
Accusation filed: 11/27/2007

KOSINS, Mark Steven, M.D.
San Clemente, CA
License number: A-25406
Accusation filed: 11/13/2007

KUTSCHBACH, Joan Zielske, M.D.
Sacramento, CA
License number: G-45803
Accusation filed: 11/29/2007

LARKIN, David, M.D.
Los Alamitos, CA
License number: C-40016
Accusation and Petition to Revoke Probation filed: 11/7/2007

LIEB, Stephen Michael, M.D.
Santa Monica, CA
License number: AFE-31504
Accusation filed: 11/27/2007

MONTENEGRO, Jose Maria Marti, M.D.
Carlsbad, CA
License number: C-35541
Accusation and Petition to Revoke Probation filed: 11/21/2007

MOUSSABECK, Omar, M.D.
Los Alamitos, CA
License number: G-58953
Accusation filed: 11/28/2007

NISHIGUCHI, Don Jerry, M.D.
Valencia, CA
License number: G-55628
Accusation filed: 10/10/2007

PARK, Chong Hee, M.D.
Livingston, NJ
License number: A-38230
Accusation filed: 11/13/2007

SIMPSON, William Bernard, M.D.
Carson, CA
License number: G-43101
Accusation filed: 11/13/2007

SMITH, Jeffrey Scott, M.D.
Midland, TX
License number: G-76071
Accusation filed: 11/27/2007

TESSLER, Irving, M.D.
Pasadena, CA
License number: G-14307
Accusation filed: 11/9/2007

YEDIDSION, Davoud, M.D.
Los Angeles, CA
License number: A-38412
Petition to Revoke Probation filed: 11/6/2007

Physical Therapist

ANJUM, Farzana
Fontana, CA
License number: PT-28186
Accusation filed: 11/7/2007

Psychologists

BYRNS, Sheila, Ph.D.
Berkeley, CA
License number: PSY-13608
Accusation filed: 11/13/2007

ROCHA-SINGH, Indra A., Ph.D.
Northridge, CA
License number: PSY-15940
Accusation filed: 11/30/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

LEE, Tan Shin, M.D.
Rowland Heights, CA
License number: A-50001
Amended Accusation filed: 11/9/2007

MODI, Jasvant N., M.D.
Los Angeles, CA
License number: A-39818
Amended Accusation filed: 11/29/2007

SAGINOR, Mark L., M.D.
Marina del Rey, CA
License number: G-8242
Amended Accusation filed: 11/30/2007

UWAYDAH, Munir, M.D.
Redondo Beach, CA
License number: A-62059
Amended Accusation filed: 11/21/2007

Psychologist

TSOPELS, Maria, Ph.D.
Cathedral City, CA
License number: PSY-16607
Amended Accusation filed: 11/26/2007

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician & Surgeon

SIDDIQI, Shafi Ullah, M.D.
Newport Beach, CA
License number: A-102176
Stipulated decision effective: 11/7/2007
3 year probationary license
issued: 11/28/2007

Physician Assistants

ADAMS, Angela Shirlene
Irvine, CA
License number: PA-19513
Stipulated decision effective: 11/27/2007
3 year probationary license
issued: 11/29/2007

DRURY, Ryan Allen
Tehachapi, CA
License number: PA-19487
Stipulated decision effective: 11/8/2007
2 year probationary license
issued: 11/14/2007

STATEMENT OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Psychologist

TILLERY, Amy
Kingsburg, CA
License number: None
Statement of Issues filed: 11/15/2007

STATEMENT OF ISSUES WITHDRAWN

Podiatrist

BALDWIN, Jeffrey John
Los Angeles, CA
License number: None
Statement of Issues withdrawn: 11/9/2007

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January 2008

The Hot Sheet - A Summary of Administrative Actions

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

BALL, Craig James
Palm Desert, CA
License number: G-38467
Stipulated decision effective: 12/31/2007
Surrender of License.

BLYWEISS, David Jared, M.D.
Fort Lauderdale, FL
License number: C-43059
Public Letter of Reprimand
issued: 12/18/2007

CASHATT, Troy D., M.D.
Los Angeles, CA
License number: A-63013
Stipulated decision effective: 12/19/2007
Revoked, stayed, 2 years probation.

COHEN, Fred Louis, M.D.
Jupiter, FL
License number: G-26472
Public Letter of Reprimand
issued: 12/6/2007

DANIEL, Thomas Alan
Sacramento, CA
License number: G-53590
Decision effective: 12/19/2007
License revoked.

ENO, Gary Ross, M.D.
Berkeley, CA
License number: A-24709
Stipulated decision effective: 11/21/2007
Public Reprimand issued: 12/7/2007

FISCH, Richard
Palo Alto, CA
License number: G-4454
Stipulated decision effective: 12/3/2007
Surrender of License.

FLETSCHER, Walter Lyle, M.D.
Redding, CA
License number: G-48644
Stipulated decision effective: 3/19/2007
Public Reprimand issued: 12/7/2007

GREWAL, Ranjit Singh, M.D.
Torrance, CA
License number: A-38510
Stipulated decision effective: 12/19/2007
Revoked, stayed, 35 months probation.

GRISOLIA, James Santiago, M.D.
San Diego, CA
License number: G-42884
Stipulated decision effective: 12/10/2007
Revoked, stayed, 7 years probation.

KRAUS, Bruce Allan, M.D.
Columbus, WI
License number: G-30793
Public Letter of Reprimand issued: 12/7/2007

NAIK, Ramdas Beeranna, M.D.
Milpitas, CA
License number: A-32981
Stipulated decision effective: 12/5/2007
Revoked, stayed, 2 years probation.

NOUSHKAM, Mohammad Bagher, M.D.
Hawaiian Gardens, CA
License number: A-45935
Stipulated decision effective: 12/17/2007
Revoked, stayed, 7 years probation.

PUBLICOVER, Laurie Downs, M.D.
San Diego, CA
License number: G-61970
Public Letter of Reprimand
issued: 12/14/2007

RESNICK, Lawrence Harold, M.D.
Santa Monica, CA
License number: G-16871
Decision effective: 12/20/2007
Public Reprimand issued.

SALMASSI, Sadegh, M.D.
Delano, CA
License number: A-39604
Stipulated decision effective: 12/7/2007
Public Reprimand issued.

SINHA, Ronesh, M.D.
Redwood City, CA
License number: A-70506
Stipulated decision effective: 10/10/2006
Public Letter of Reprimand
issued: 12/17/2007

WARNER, Clarence Emanuel
Sherman Oaks, CA
License number: G-62334
Stipulated decision effective: 12/6/2007
Surrender of License.

Physician Assistant

PAYNE, Keith Tyler
Fallbrook, CA
License number: PA-14225
Stipulated decision effective: 12/28/2007
Revoked, stayed, 3 1/2 years probation.

Physical Therapists

SAADAT, Mimi
Yorba Linda, CA
License number: PT-11203
Stipulated decision effective: 12/3/2007
Revoked, stayed, 5 years probation with
5 days actual suspension.

WRIGHT, Richard Scott
Vista, CA
License number: PT-9924
Stipulated decision effective: 12/3/2007
Revoked, stayed, 5 years probation.

Physical Therapist Assistant

RONQUILIO, Donna Kay
Redlands, CA
License number: AT-3651
Decision effective: 12/19/2007
Revoked, stayed, 5 years probation.

Podiatrist

ALVARO, Michael S., D.P.M.
Los Angeles, CA
License number: E-3777
Stipulated decision effective: 12/31/2007
Revoked, stayed, 5 years probation.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

ARORA, Ajit Singh, M.D.
Agua Dulce, CA
License number: G-47654
Accusation filed: 12/6/2007

BABAALI, Hossein, M.D.
Los Angeles, CA
License number: G-86162
Accusation filed: 12/3/2007

BRANNIGAN, John, M.D.
Los Banos, CA
License number: A-77781
Accusation filed: 11/28/2007

CABANSAG, Dean Allan, M.D.
Arlington, TX
License number: A-60858
Accusation filed: 12/3/2007

HANSEN, Ralph Stuart, M.D.
Manhattan Beach, CA
License number: G-41057
Accusation filed: 12/3/2007

KIM, Jeannie, M.D.
San Diego, CA
License number: A-72965
Accusation filed: 12/11/2007

PHEN, Lovsho, M.D.
Brentwood, CA
License number: A-43266
Accusation filed: 12/24/2007

SABATINI, John Robert, M.D.
Torrance, CA
License number: G-31402
Accusation filed: 12/28/2007

SMOLKO, Milan John, M.D.
Clarks Summit, PA
License number: G-37798
Accusation filed: 12/3/2007

TRAN, Thanh Ngoc, M.D.
South Gate, CA
License number: A-40326
Accusation filed: 12/20/2007

Podiatrists

LAWRENCE, Eric U., D.P.M.
Northridge, CA
License number: E-4288
Accusation filed: 12/11/2007

STRUGATSKY, Igor D., D.P.M.
La Jolla, CA
License number: E-4369
Accusation filed: 12/6/2007

Psychologist

SUITER, Robert L., Ph.D.
Riverside, CA
License number: PSY-9946
Accusation filed: 12/20/2007

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

FLORES, Byron, M.D.
Burbank, CA
License number: A-52173
Amended Accusation filed: 12/20/2007

KAHN, Otto, M.D.
Arcadia, CA
License number: G-14298
Amended Accusation filed: 12/21/2007

LEE, Jae Hong, M.D.
San Diego, CA
License number: G-81426
Amended Accusation filed: 12/11/2007

MORA, William Edward, M.D.
Phoenix, AZ
License number: G-53726
Amended Accusation filed: 12/7/2007

REISBORD, David A., M.D.
Los Angeles, CA
License number: G-8913
Amended Accusation filed: 12/3/2007

SHAW, David Graeme, M.D.
Los Altos, CA
License number: G-47925
Amended Accusation filed: 12/24/2007

SHIMA, Gary James, M.D.
San Marcos, CA
License number: G-14742
Amended Accusation filed: 11/29/2007

WEST, Brian Robert, M.D.
Huntington Beach, CA
License number: G-65175
Amended Accusation filed: 11/28/2007

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

BAUM, Phillip Adam, M.D.
Buffalo, NY
License number: G-71465
Accusation withdrawn: 12/28/2007

VANSPEYBROECK, John Arthur, M.D.
Eureka, CA
License number: G-28829
Accusation dismissed: 12/20/2007

Physician Assistant

NELSON, Peter William
Redondo Beach, CA
License number: PA-16082
Accusation withdrawn: 12/4/2007

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician & Surgeon

REYZIN, Gary Igor, M.D.
Northridge, CA
License number: A-102312
Stipulated decision effective: 12/6/2007
3 year probationary license
issued: 12/12/2007

STATEMENT OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Physician & Surgeon

RAFIE, Ramin
Columbus, OH
License number: None
Statement of Issues filed: 12/12/2007

STATEMENT OF ISSUES DECISION

Registered Psychological Assistant

DAVIS, Bobby J.
Sacramento, CA
Registration number: RPS-2007177
Stipulated decision effective: 12/14/2007
Registration granted, revoked, stayed, 3 years probation.

These are recent administrative actions. The decisions become operative on the effective date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decisions, which are negotiated settlements waiving court appeals.

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February 2008

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- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

BARCKLAY, Karen Beth
Walnut Creek, CA
License number: A-69028
Stipulated decision effective: 1/3/2008
Surrender of License.

CAMPBELL, Elizabeth Trupin, M.D.
Walnut Creek, CA
License number: A-40036
Stipulated decision effective: 1/18/2008
Revoked, stayed, 5 years probation.

COULSON, Alan Stewart
Hamlet, NC
License number: A-25297
Stipulated decision effective: 1/22/2008
Surrender of License.

DONLEY-KIMBLE, Irene, M.D.
San Bernardino, CA
License number; G-42558
Decision effective: 1/28/2008
Revoked, stayed, 5 years probation.

EPSTEIN, Larry A., M.D.
Mountain View, CA
License number: C-24787
Stipulated decision effective: 6/18/2007
Public Reprimand issued: 1/28/2008

FLORES, Jorge N.
Hacienda Heights, CA
License number: A-33705
Decision effective: 1/4/2008
License revoked.

GOLDEN, Patrick Allen, M.D.
Fresno, CA
License number: G-51665
Stipulated decision effective: 1/28/2008
Revoked, stayed, 5 years probation.

JOHNSON, Gary Ronald, M.D.
San Andreas, CA
License number: G-27755
Stipulated decision effective: 1/30/2008
Revoked, stayed, 5 years probation.

LANG, Aaron aka LANG, Erin Hong-Dao
Bend, OR
License number: A-44528
Stipulated decision effective: 1/16/2008
Surrender of License.

LEMUS, Julio Fernando, M.D.
Los Angeles, CA
License number: A-44494
Decision effective: 1/16/2008
Revoked, stayed, 5 years probation.

LOOS, Donald C., M.D.
Bakersfield, CA
License number: A-17613
Stipulated decision effective: 1/10/2008
Revoked, stayed, 5 years probation.

PHAM, Co Dang Long, M.D.
Westminster, CA
License number: A-34091
Stipulated decision effective: 1/3/2008
Public Reprimand issued.

RAJARATNAM, John Namala S., M.D.
Huntington Beach, CA
License number: A-51207
Decision effective: 1/2/2008
Revoked, stayed, 5 years probation with 1 year actual suspension.

REISBORD, David A.
Los Angeles, CA
License number: G-8913
Stipulated decision effective: 1/15/2008
Surrender of License.

SAHAFI, Fereydoun, M.D.
Mission Viejo, CA
License number: A-52188
Stipulated decision effective: 1/10/2008
Revoked, stayed, 5 years probation with 30 days actual suspension.

SENGELMANN, Robert Paul
Canoga Park, CA
License number: G-16979
Stipulated decision effective: 1/11/2008
Surrender of License.

SHAMSIAN, Saeid
Great Neck, NY
License number: A-40648
Surrender of License: 1/22/2008

SMITH, Andrew James Kendrc
Santa Monica, CA
License number: A-60393
Decision effective: 1/4/2008
License revoked.

TURULLOLS, Gildardo
Chula Vista, CA
License number: A-39240
Stipulated decision effective: 1/5/2008
Surrender of License.

Physician Assistant

PUGLIESE, William Francis
Santa Ana, CA
License number: PA-12876
Decision effective: 1/17/2008
License revoked.

Psychologist

LAMBERT, Scott W.
North Hollywood, CA
License number: PSY-12547
Stipulated decision effective: 1/28/2008
Surrender of License.

ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

AGUAS, Jesus Morales, M.D.
Glendale, CA
License number: A-34280
Accusation filed: 1/29/2008

AJIGBOTAFE, Christopher I., M.D.
Bellflower, CA
License number: A-42564
Accusation filed: 1/30/2008

BALDWIN, Kenneth Leslie, M.D.
San Luis Obispo, CA
License number: G-34268
Accusation filed: 1/2/2008

BUI, Can Quoc, M.D.
San Diego, CA
License number: A-39900
Accusation filed: 1/25/2008

FITZPATRICK, Christian John, M.D.
Las Vegas, NM
License number: G-47520
Accusation filed: 1/17/2008

HINOSTROZA, Felix Manuel, M.D.
Pomona, CA
License number: A-29613
Accusation filed: 1/30/2008

JUNG, James Man-Gil, M.D.
Los Angeles, CA
License number: A-48898
Accusation filed: 1/22/2008

KELLETT, Richard Stanley, M.D.
Greenville, SC
License number: A-74713
Accusation filed: 1/18/2008

LORENZANA, Vona Wright, M.D.
Lafayette, CA
License number: G-71680
Accusation filed: 1/2/2008

LUCHETTI, Mary Ellen Joan, M.D.
Smyrna, GA
License number: G-65392
Accusation filed: 1/24/2008

MILLER, Stephen P., M.D.
Houston, TX
License number: G-16153
Accusation filed: 1/17/2008

MODNY, Cynthia Jean, M.D.
Phoenix, AZ
License number: CFE-34520
Accusation filed: 1/18/2008

NEWTON, William Lee, M.D.
Portland, OR
License number: C-34415
Accusation filed: 1/25/2008

NGUYEN, An Minh M.D.
El Monte, CA
License number: A-54288
Accusation filed: 1/29/2008

NIEMANN, Petra Susanne, M.D.
Munich, Germany
License number: A-76281
Accusation filed: 1/28/2008

NOVELL, Laura Ann, M.D.
Mountain View, HI
License number: A-88754
Accusation filed: 1/31/2008

PAYNE, Brownell Hilliard, M.D.
Culver City, CA
License number: A-26350
Accusation filed: 1/23/2008

PHAN, Andy, M.D.
Visalia, CA
License number: A-75547
Accusation filed: 1/23/2008

PIERCE, John Winthrop, M.D.
San Francisco, CA
License number: G-45225
Accusation filed: 1/9/2008

PRICE, Michael Richard, M.D.
Brawley, CA
License number: G-36055
Accusation filed: 1/25/2008

ROQUE, Andrew A., M.D.
Monterey Park, CA
License number: A-19578
Accusation filed: 1/24/2008

SIROIS, Cindy Hang, M.D.
Minnetonka, MN
License number: A-71013
Accusation filed: 1/25/2008

SOBECK, Gregg Robert, M.D.
Sherman Oaks, CA
License number: A-68256
Accusation filed: 1/24/2008

SPECTOR, Robert Ira, M.D.
Los Angeles, CA
License number: G-24756
Accusation filed: 1/17/2008

STEEVER, Calvin S., M.D.
Santa Rosa, CA
License number: C-20726
Accusation filed: 1/25/2008

STILES, Wendy Laura, M.D.
Los Gatos, CA
License number: A-93192
Accusation filed: 1/25/2008

Physical Therapists

DAVIDSON, Kenneth Howard
Redwood Valley, CA
License number: PT-7433
Accusation filed: 1/29/2008

SHIRINZADEH, Rafat
Pasco, WA
License number: PT-23416
Accusation filed: 1/18/2008

Podiatrists

ALLEN, Kirk Robert, D.P.M.
Monterey, CA
License number: E-1923
Accusation filed: 1/17/2008

BRIM, Mark Avery, D.P.M.
Encino, CA
License number: E-1542
Accusation filed: 1/8/2008

Psychologist

RAVICZ, Simone, Ph.D.
Palm Springs, CA
License number: PSY-15512
Accusation filed: 1/16/2008

AMENDED ACCUSATIONS AND/ OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

FRITCH, Charles David, M.D.
Bakersfield, CA
License number: C-33729
Amended Accusation filed: 1/4/2008

HARTNETT, John Michael, M.D.
Mill Valley, CA
License number: G-72166
Amended Accusation filed: 1/2/2008

JENKINS, Michael Hawley, M.D.
Portland, OR
License number: A-22627
Amended Accusation filed: 1/22/2008

MORA, William Edward, M.D.
Phoenix, AZ
License number: G-53726
Amended Accusation filed: 1/30/2008

Physician Assistant

LISTER, Christopher Henry, Sr.
Hesperia, CA
License number: PA-14614
Amended Accusation filed: 1/18/2008

Psychologist

COYNE, Paul D., Ph.D.
Encinitas, CA
License number: PSY-7144
Amended Accusation filed: 1/16/2008

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation "withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

AHDOOT, Roben Dan, M.D.
Los Angeles, CA
License number: A-62395
Accusation withdrawn: 1/24/2008

BYRNE, Brian Anthony, M.D.
Wildomar, CA
License number: A-39837
Accusation dismissed: 1/28/2008

DELA CRUZ, Teddy Villegas, M.D.
Beverly Hills, CA
License number: C-50232
Accusation withdrawn: 1/29/2008

KELLY, Adrienne Moore, M.D.
San Diego, CA
License number: A-69080
Accusation withdrawn: 1/17/2008

STATEMENT OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Podiatrist

LEE, Jake Israel Kai
Oakland, CA
License number: EI-1732
Statement of Issues filed: 1/4/2008

STATEMENT OF ISSUES DECISION

Podiatrist

LEE, Jake Israel Kai, D.P.M.
Oakland, CA
License number: EL-1732
Stipulated decision effective: 1/29/2008
License granted, revoked, stayed with 3 years probation.

These are recent administrative actions. The decisions become operative on the effective date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decisions, which are negotiated settlements waiving court appeals.

Copies of decisions and other documents are available at no cost at www.mbc.ca.gov.

You may also send your written request, including the name and license number of the licensee, to:

Medical Board of California
Enforcement Program
Central File Room
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

MEDICAL BOARD OF CALIFORNIA
Discipline Coordination Unit

THE HOT SHEET – A SUMMARY OF ADMINISTRATIVE ACTIONS
March 2008

Electronic copies of these documents are available at no cost at www.mbc.ca.gov

A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

BELVILLE, John Scott, M.D.
Mission Viejo, CA
License number: G-65179
Stipulated decision effective: 2/6/2008
Revoked, stayed, 5 years probation.

COSGROVE, Zachary King
Bakersfield, CA
License number: A-70710
Stipulated decision effective: 2/19/2008
Surrender of License.

COUTURE, Larry Henry, M.D.
Riverside, CA
License number: A-63843
Stipulated decision effective: 2/19/2008
Public Reprimand issued.

ELLIOTT, Robert Michael, M.D.
Los Angeles, CA
License number: G-29258
Stipulated decision effective: 2/28/2008
Revoked, stayed, 35 months probation with 15 days actual suspension.

GRANT-ANDERSON, Betty Sue, M.D.
Moreno Valley, CA
License number: G-55694
Decision effective: 2/11/2008
Revoked, stayed, 5 years probation.

HANSEN, Ralph Stuart
Manhattan Beach, CA
License number: G-41057
Stipulated decision effective: 2/4/2008
Surrender of License.

HYSHAW, Clarence Moody, M.D.
Inglewood, CA
License number: A-26220
Decision effective: 2/13/2008
Public Reprimand issued.

JORDAN, Irene Ow Gleason
Palmdale, CA
License number: A-14408
Decision effective: 2/19/2008
License revoked.

KAPELEVICH , Diana L.
Los Angeles, CA
License number: A-44245
Stipulated decision effective: 2/15/2008
Surrender of License.

KALINA, Mark Evan, M.D.
Del Mar, CA
License number: A-49274
Stipulated decision effective: 2/25/2008
Public Reprimand issued.

KWONG, Myron S., M.D.
San Jose, CA
License number: A-86563
Stipulated decision effective: 2/28/2008
Revoked, stayed, 2 years probation.

LEE, Jae Hong, M.D.
San Diego, CA
License number: G-81426
Stipulated decision effective: 2/11/2008
Public Reprimand issued.

MALAYAN, Samuel Ara, M.D.
Glendale, CA
License number: G-61143
Stipulated decision effective: 2/11/2008
Revoked, stayed, 24 months probation.

MIRANDA, Frederick Ralph, M.D.
Salinas, CA
License number: A-30370
Decision effective: 2/22/2008
Revoked, stayed, 5 years probation.

MORRIS, David Jack
Price, UT
License number: G-28067
Decision effective: 2/8/2008
License revoked.

NGUYEN An Minh
El Monte, CA
License number: A-54288
Stipulated decision effective: 2/20/2008
Surrender of License.

O'DELL, Kevin Bruce
Shelby, NC
License number: C-42660
Stipulated decision effective: 2/5/2008
Surrender of License.

PAIGNE, Kittya, M.D.
Long Beach, CA
License number: G-79550
Stipulated decision effective: 2/15/2008
Revoked, stayed, 5 years probation.

RASTEGAR-FARD, Hassan, M.D.
Los Angeles, CA
License number: A-53847
Stipulated decision effective: 2/25/2008
Revoked, stayed, 3 years probation.

ROBINSON, Wayne Lester, M.D.
Irvine, CA
License number: C-24438
Stipulated decision effective: 2/22/2008
Revoked, stayed, 4 years probation.

ROSARIO, Benjamin Zamora
Council Bluffs, IA
License number: C-41073
Stipulated decision effective: 2/22/2008
Surrender of License.

SHIH, Hsien Shou, M.D.
Temple City, CA
License number: A-41812
Decision effective: 2/11/2008
Revoked, stayed, 10 years probation.

SULEIMAN, Mustafa Ismail, M.D.
Seal Beach, CA
License number: A-48051
Decision effective: 2/28/2008
Revoked, stayed, 5 years probation.

VO, Cau Van, M.D.
Westminster, CA
License number: A-43680
Stipulated decision effective: 2/7/2008
Public Reprimand issued.

VOGT, Walter Arnold
San Jose, CA
License number: G-87134
Decision effective: 2/21/2008
License revoked.

WADE, Mark Robert
Germantown, TN
License number: G-47936
Decision effective: 2/4/2008
Surrender of License.

Physician Assistant

CAPURRO, Peter Anthony
Los Angeles, CA
License number: PA-17235
Decision effective: 2/11/2008
License revoked.

Physical Therapists

POSADA, Romel A.
San Clemente, CA
License number: PT-18668
Stipulated decision effective: 2/28/2008
Public Reprimand issued.

WILLIAMS, William David
Boulder, CO
License number: PT-29643
Stipulated decision effective: 2/15/2008
Public Reprimand issued.

ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

CHEN, Dennis Hui-Ting, M.D.
Newport Beach, CA
License number: A-26597
Accusation filed: 2/11/2008

CHUNG, Wayne, M.D.
San Francisco, CA
License number: A-63888
Accusation filed: 2/10/2008

COATES, Reginald Alvin, M.D.
West Hills, CA
License number: G-37252
Accusation filed: 2/25/2008

FRY, Marion P., M.D.
Cool, CA
License number: G-57771
Accusation filed: 2/29/2008

GEORGESON, George D., M.D.
Garden Grove, CA
License number: A-40874
Accusation filed: 2/15/2008

KNORR, Philip Andrew, M.D.
Freedom, CA
License number: G-56315
Accusation filed: 2/22/2008

KUZNETSKY, Charles A., M.D.
Reseda, CA
License number: C-9890
Accusation filed: 2/1/2008

RICHARDSON, Fred Douglas, M.D.
Elk Grove, CA
License number: C-42974
Accusation filed: 2/19/2008

SCHAFLE, Michael F., M.D.
Fortuna, CA
License number: C-42249
Accusation filed: 2/6/2008

SINGER, Joel Barnett, M.D.
Westport, CT
License number: G-65205
Accusation filed: 2/4/2008

SWEENEY, Michael Alan, M.D.
Santa Rosa, CA
License number: G-61169
Accusation filed: 2/20/2008

TER-OHANESSIAN, Srbouhi, M.D.
Los Angeles, CA
License number: A-46038
Accusation filed: 2/7/2008

Physician Assistant

HAUSER, Christian Chavat
La Habra Heights, CA
License number: PA-13847
Accusation filed: 2/5/2008

Physical Therapists

ERTMAN, Danny L.
Arcata, CA
License number: PT-19615
Accusation filed: 2/7/2008

MAYNER, Mark A.
Mishawaka, IN
License number: PT-24948
Accusation filed: 2/1/2008

Physical Therapist Assistant

THOMAS, Gloria E.
Victorville, CA
License number: AT-5792
Accusation filed: 2/28/2008

AMENDED ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

LUNG, Roy Chi Wing, M.D.
Torrance, CA
License number: A-53998
Amended Accusation filed: 2/21/2008

PATEL, Jyotinkumar K., M.D.
Laguna Niguel, CA
License number: A-43752
Amended Accusation filed: 2/20/2008

WATSON, Louis Herman, M.D.
Claremont, CA
License number: G-32156
Amended Accusation and Petition to Revoke Probation filed: 2/15/2008

WEST, Brian Robert, M.D.
Huntington Beach, CA
License number: G-65175
Amended Accusation filed: 2/20/2008

Psychologist

RAND, Randy, Ph.D.
Mill Valley, CA
License number: PSY-12137
Amended Accusation filed: 2/29/2008

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation 'withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

CHAMBI VENERO, Israel Pedro, M.D.
Santa Ana, CA
License number: A-34163
Accusation withdrawn: 2/27/2008

GAMBLE, Robert Clifton, M.D.
Clovis, CA
License number: C-42796
Accusation withdrawn: 2/13/2008

KOH, Kee Seng, M.D.
Arcadia, CA
License number: A-30888
Accusation withdrawn: 2/1/2008

PIRNAZAR, Cyrus, M.D.
Los Angeles, CA
License number: A-22671
Accusation withdrawn: 2/8/2008

SMITH, Brenton Robert, M.D.
Riverdale, CA
License number: A-36249
Accusation dismissed: 2/29/2008

TA, Viet Duy, M.D.
Rancho Cucamonga, CA
License number: A-69957
Accusation dismissed: 2/8/2008

TESSLER, Irving, M.D.
Pasadena, CA
License number: G-14307
Accusation withdrawn: 2/25/2008

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician Assistant

ALLEN, Jason Isong
Etiwanda, CA
License number: PA-19615
Stipulated Decision effective: 2/8/2008
1 year probationary license issued: 2/13/2008

Physical Therapist Assistant

DAVIS, Willie Anthony
San Diego, CA
License number: AT-8670
3 year probationary license issued: 2/26/2008

STATEMENTS OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Physicians & Surgeons

BETTENCOURT, Robert Brian
Canoga Park, CA
License number: None
Statement of Issues filed: 2/1/2008

CEPHAS, Gerald
Aliso Viejo, CA
License number: None
Statement of Issues filed: 2/28/2008

DUSICK, Joshua Robert
Los Angeles, CA
License number: None
Statement of Issues filed: 2/14/2008

Psychologist

EDWARDS-MORSE, Eugia
San Diego, CA
License number: None
Statement of Issues filed: 2/27/2008

These are recent administrative actions. The decisions become operative on the effective date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decisions, which are negotiated settlements waiving court appeals.

Copies of decisions and other documents are available at no cost at www.mbc.ca.gov.

You may also send your written request, including the name and license number of the licensee, to:

Medical Board of California
Enforcement Program
Central File Room
2005 Evergreen Street
Sacramento, CA 95815

MEDICAL BOARD OF CALIFORNIA
Discipline Coordination Unit

THE HOT SHEET – A SUMMARY OF ADMINISTRATIVE ACTIONS
March 2008

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- *Physician Assistant Committee*
- *Physical Therapy Board of California*
- *Board of Podiatric Medicine*
- *Board of Psychology*

DECISIONS

Physicians & Surgeons

BELVILLE, John Scott, M.D.
Mission Viejo, CA
License number: G-65179
Stipulated decision effective: 2/6/2008
Revoked, stayed, 5 years probation.

COSGROVE, Zachary King
Bakersfield, CA
License number: A-70710
Stipulated decision effective: 2/19/2008
Surrender of License.

COUTURE, Larry Henry, M.D.
Riverside, CA
License number: A-63843
Stipulated decision effective: 2/19/2008
Public Reprimand issued.

ELLIOTT, Robert Michael, M.D.
Los Angeles, CA
License number: G-29258
Stipulated decision effective: 2/28/2008
Revoked, stayed, 35 months probation with 15 days actual suspension.

GRANT-ANDERSON, Betty Sue, M.D.
Moreno Valley, CA
License number: G-55694
Decision effective: 2/11/2008
Revoked, stayed, 5 years probation.

HANSEN, Ralph Stuart
Manhattan Beach, CA
License number: G-41057
Stipulated decision effective: 2/4/2008
Surrender of License.

HYSHAW, Clarence Moody, M.D.
Inglewood, CA
License number: A-26220
Decision effective: 2/13/2008
Public Reprimand issued.

JORDAN, Irene Ow Gleason
Palmdale, CA
License number: A-14408
Decision effective: 2/19/2008
License revoked.

KAPELEVICH , Diana L.
Los Angeles, CA
License number: A-44245
Stipulated decision effective: 2/15/2008
Surrender of License.

KALINA, Mark Evan, M.D.
Del Mar, CA
License number: A-49274
Stipulated decision effective: 2/25/2008
Public Reprimand issued.

KWONG, Myron S., M.D.
San Jose, CA
License number: A-86563
Stipulated decision effective: 2/28/2008
Revoked, stayed, 2 years probation.

LEE, Jae Hong, M.D.
San Diego, CA
License number: G-81426
Stipulated decision effective: 2/11/2008
Public Reprimand issued.

MALAYAN, Samuel Ara, M.D.
Glendale, CA
License number: G-61143
Stipulated decision effective: 2/11/2008
Revoked, stayed, 24 months probation.

MIRANDA, Frederick Ralph, M.D.
Salinas, CA
License number: A-30370
Decision effective: 2/22/2008
Revoked, stayed, 5 years probation.

MORRIS, David Jack
Price, UT
License number: G-28067
Decision effective: 2/8/2008
License revoked.

NGUYEN An Minh
El Monte, CA
License number: A-54288
Stipulated decision effective: 2/20/2008
Surrender of License.

O'DELL, Kevin Bruce
Shelby, NC
License number: C-42660
Stipulated decision effective: 2/5/2008
Surrender of License.

PAIGNE, Kittya, M.D.
Long Beach, CA
License number: G-79550
Stipulated decision effective: 2/15/2008
Revoked, stayed, 5 years probation.

RASTEGAR-FARD, Hassan, M.D.
Los Angeles, CA
License number: A-53847
Stipulated decision effective: 2/25/2008
Revoked, stayed, 3 years probation.

ROBINSON, Wayne Lester, M.D.
Irvine, CA
License number: C-24438
Stipulated decision effective: 2/22/2008
Revoked, stayed, 4 years probation.

ROSARIO, Benjamin Zamora
Council Bluffs, IA
License number: C-41073
Stipulated decision effective: 2/22/2008
Surrender of License.

SHIH, Hsien Shou, M.D.
Temple City, CA
License number: A-41812
Decision effective: 2/11/2008
Revoked, stayed, 10 years probation.

SULEIMAN, Mustafa Ismail, M.D.
Seal Beach, CA
License number: A-48051
Decision effective: 2/28/2008
Revoked, stayed, 5 years probation.

VO, Cau Van, M.D.
Westminster, CA
License number: A-43680
Stipulated decision effective: 2/7/2008
Public Reprimand issued.

VOGT, Walter Arnold
San Jose, CA
License number: G-87134
Decision effective: 2/21/2008
License revoked.

WADE, Mark Robert
Germantown, TN
License number: G-47936
Decision effective: 2/4/2008
Surrender of License.

Physician Assistant

CAPURRO, Peter Anthony
Los Angeles, CA
License number: PA-17235
Decision effective: 2/11/2008
License revoked.

Physical Therapists

POSADA, Romel A.
San Clemente, CA
License number: PT-18668
Stipulated decision effective: 2/28/2008
Public Reprimand issued.

WILLIAMS, William David
Boulder, CO
License number: PT-29643
Stipulated decision effective: 2/15/2008
Public Reprimand issued.

ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

CHEN, Dennis Hui-Ting, M.D.
Newport Beach, CA
License number: A-26597
Accusation filed: 2/11/2008

CHUNG, Wayne, M.D.
San Francisco, CA
License number: A-63888
Accusation filed: 2/10/2008

COATES, Reginald Alvin, M.D.
West Hills, CA
License number: G-37252
Accusation filed: 2/25/2008

FRY, Marion P., M.D.
Cool, CA
License number: G-57771
Accusation filed: 2/29/2008

GEORGESON, George D., M.D.
Garden Grove, CA
License number: A-40874
Accusation filed: 2/15/2008

KNORR, Philip Andrew, M.D.
Freedom, CA
License number: G-56315
Accusation filed: 2/22/2008

KUZNETSKY, Charles A., M.D.
Reseda, CA
License number: C-9890
Accusation filed: 2/1/2008

RICHARDSON, Fred Douglas, M.D.
Elk Grove, CA
License number: C-42974
Accusation filed: 2/19/2008

SCHAFLE, Michael F., M.D.
Fortuna, CA
License number: C-42249
Accusation filed: 2/6/2008

SINGER, Joel Barnett, M.D.
Westport, CT
License number: G-65205
Accusation filed: 2/4/2008

SWEENEY, Michael Alan, M.D.
Santa Rosa, CA
License number: G-61169
Accusation filed: 2/20/2008

TER-OHANESSIAN, Srbouhi, M.D.
Los Angeles, CA
License number: A-46038
Accusation filed: 2/7/2008

Physician Assistant

HAUSER, Christian Chavat
La Habra Heights, CA
License number: PA-13847
Accusation filed: 2/5/2008

Physical Therapists

ERTMAN, Danny L.
Arcata, CA
License number: PT-19615
Accusation filed: 2/7/2008

MAYNER, Mark A.
Mishawaka, IN
License number: PT-24948
Accusation filed: 2/1/2008

Physical Therapist Assistant

THOMAS, Gloria E.
Victorville, CA
License number: AT-5792
Accusation filed: 2/28/2008

AMENDED ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

LUNG, Roy Chi Wing, M.D.
Torrance, CA
License number: A-53998
Amended Accusation filed: 2/21/2008

PATEL, Jyotinkumar K., M.D.
Laguna Niguel, CA
License number: A-43752
Amended Accusation filed: 2/20/2008

WATSON, Louis Herman, M.D.
Claremont, CA
License number: G-32156
Amended Accusation and Petition to Revoke Probation filed: 2/15/2008

WEST, Brian Robert, M.D.
Huntington Beach, CA
License number: G-65175
Amended Accusation filed: 2/20/2008

Psychologist

RAND, Randy, Ph.D.
Mill Valley, CA
License number: PSY-12137
Amended Accusation filed: 2/29/2008

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation 'withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

CHAMBI VENERO, Israel Pedro, M.D.
Santa Ana, CA
License number: A-34163
Accusation withdrawn: 2/27/2008

GAMBLE, Robert Clifton, M.D.
Clovis, CA
License number: C-42796
Accusation withdrawn: 2/13/2008

KOH, Kee Seng, M.D.
Arcadia, CA
License number: A-30888
Accusation withdrawn: 2/1/2008

PIRNAZAR, Cyrus, M.D.
Los Angeles, CA
License number: A-22671
Accusation withdrawn: 2/8/2008

SMITH, Brenton Robert, M.D.
Riverdale, CA
License number: A-36249
Accusation dismissed: 2/29/2008

TA, Viet Duy, M.D.
Rancho Cucamonga, CA
License number: A-69957
Accusation dismissed: 2/8/2008

TESSLER, Irving, M.D.
Pasadena, CA
License number: G-14307
Accusation withdrawn: 2/25/2008

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician Assistant

ALLEN, Jason Isong
Etiwanda, CA
License number: PA-19615
Stipulated Decision effective: 2/8/2008
1 year probationary license issued: 2/13/2008

Physical Therapist Assistant

DAVIS, Willie Anthony
San Diego, CA
License number: AT-8670
3 year probationary license issued: 2/26/2008

STATEMENTS OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Physicians & Surgeons

BETTENCOURT, Robert Brian
Canoga Park, CA
License number: None
Statement of Issues filed: 2/1/2008

CEPHAS, Gerald
Aliso Viejo, CA
License number: None
Statement of Issues filed: 2/28/2008

DUSICK, Joshua Robert
Los Angeles, CA
License number: None
Statement of Issues filed: 2/14/2008

Psychologist

EDWARDS-MORSE, Eugia
San Diego, CA
License number: None
Statement of Issues filed: 2/27/2008

These are recent administrative actions. The decisions become operative on the effective date, except in situations where the licensee obtains a court ordered stay. This may occur after the publication of the administrative action in the Hot Sheet. Stay orders do not occur in stipulated decisions, which are negotiated settlements waiving court appeals.

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Medical Board of California
Enforcement Program
Central File Room
2005 Evergreen Street
Sacramento, CA 95815

MEDICAL BOARD OF CALIFORNIA
Discipline Coordination Unit

THE HOT SHEET – A SUMMARY OF ADMINISTRATIVE ACTIONS
April 2008

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A monthly summary of administrative matters for the Medical Board of California and the following boards and committee:

- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

AMINI, Shamim, M.D.
Oxnard, CA
License number: A-96250
Stipulated decision effective: 3/31/2008
Revoked, stayed, 7 years probation with 30 days actual suspension.

ANDERSON, Donovan John, M.D.
Mohave Valley, AZ
License number: G-48061
Stipulated decision effective: 9/19/2007
Public Reprimand issued: 3/25/2008

ANSAR, Azber, Azher, M.D.
Saint Paul, MN
License number: A-84893
Decision effective: 3/21/2008
Revoked, stayed, 5 years probation with 90 days actual suspension.

BAHNA, Mamdouh Sadek
Los Angeles, CA
License number: A-26744
Stipulated decision effective: 3/11/2008
Surrender of License.

BOHEE, Sumner T.
Los Angeles, CA
License number: C-17942
Stipulated decision effective: 3/17/2008
Surrender of License.

DOSSETT, Lucy Maryanna, M.D.
Dallas, TX
License number: A-51448
Public Letter of Reprimand issued: 3/3/2008

DURON, Paul Adolph, M.D.
Lancaster, CA
License number: A-50452
Stipulated decision effective: 8/16/2007
Public Reprimand issued: 3/2/2008

GALLOWAY, Carl Anthony, M.D.
Los Angeles, CA
License number: C-35766
Stipulated decision effective: 3/24/2008
Revoked, stayed, 6 years probation from commencement of existing probation.

HAGEN, Karl Matthew, M.D.
Orlando, FL
License number: G-70206
Public Letter of Reprimand issued: 3/26/2008

HARTNETT, John Michael
Mill Valley, CA
License number: G-72166
Stipulated decision effective: 3/6/2008
Surrender of License within 60 days.

HONDA, James I.
Fullerton, CA
License number: A-21748
Stipulated decision effective: 3/13/2008
Surrender of License.

INGRAM, Alice Michelle, M.D.
Aberdeen, UK
License number: A-65769
Stipulated decision effective: 3/6/2008
Revoked, stayed, 5 years probation.

KIM, Joong Wan, M.D.
Los Angeles, CA
License number: A-36121
Stipulated decision effective: 6/11/2007
Public Reprimand issued: 3/25/2008

KUMAR, Kain, M.D.
Palmdale, CA
License number: A-67882
Stipulated decision effective: 6/4/2007
Public Reprimand issued: 3/10/2008

MILLER, Stuart Craig, M.D.
Pasadena, CA
License number: G-47045
Decision effective: 3/5/2007
Public Reprimand issued: 3/5/2008

MITCHELL, Thomas Evans, Jr., M.D.
Pasadena, CA
License number: G-54207
Decision effective: 3/10/2008
Revoked, stayed, 5 years probation.

MODNY, Cynthia Jean
Phoenix, AZ
License number: CFE-34520
Stipulated decision effective: 3/17/2008
Surrender of License.

MORA, William Edward
Phoenix, AZ
License number: G-53726
Stipulated decision effective: 3/18/2008
Surrender of License.

PHAM, Khanh Gia, M.D.
Westminster, CA
License number: A-41805
Stipulated decision effective: 3/3/2008
Revoked, stayed, 35 months probation.

QUADRO, Robert Elton, M.D.
Sacramento, CA
License number: G-40361
Stipulated decision effective: 7/26/2007
Public Reprimand issued: 3/10/2008

SAGINOR, Mark L., M.D.
Marina del Rey, CA
License number: G-8242
Decision effective: 3/3/2008
Revoked, stayed, 5 years probation.

SHIVELY, Donovan Paul, M.D.
Fairfield, CA
License number: G-21888
Decision effective: 7/27/2006
Public Reprimand issued: 3/5/2008

STEEVER, Calvin S.
Santa Rosa, CA
License number: C-20726
Stipulated decision effective: 3/4/2008
Surrender of License.

Revoked, stayed, 3 years probation.

TATE, Harold Austin, M.D.
Las Vegas, NV
License number: G-74583
Stipulated decision effective: 3/21/2008
Revoked, stayed, 5 years probation with 15 days actual suspension.

ZIMMERMAN, Kimberly Rose, M.D.
Shadow Hills, CA
License number: A-45334
Stipulated decision effective: 3/21/2008
Public Reprimand issued.

Physician Assistant

ACEVEDO-SCHOUPS, Antonia A.
Monterey, CA
License number: PA-13324
Stipulated decision effective: 3/10/2008
Revoked, stayed, 5 years probation.

Podiatrist

SPLETTSTOESSER, James W., D.P.M.
Santa Barbara, CA
License number: E-1960
Decision effective: 3/3/2008
Revoked, stayed, 3 years probation added to existing probation.

Physical Therapists

HERNANDEZ, Ruel Funtila
Fontana, CA
License number: PT-27335
Stipulated decision effective: 3/3/2008
Revoked, stayed 3 years probation with 7 days actual suspension.

TURNER, David George
Livermore, CA
License number: PT-18170
Stipulated decision effective: 3/3/2008
Public Reprimand issued.

Physical Therapist Assistant

ABELLA, Regie R.
Danville, CA
License number: AT-2692
Stipulated decision effective: 3/3/2008
Public Reprimand issued.

Psychologists

KAUFMAN, Valerie, Ph.D.
Los Angeles, CA
License number: PSY-13480
Decision effective: 3/3/2008
Revoked, stayed, 5 years probation.

MARQUIS, John N., Ph.D.
Los Altos, CA
License number: PSY-2714
Stipulated decision effective: 3/3/2008
Revoked, stayed, 3 years probation.

SELLS, Christine, Ph.D.
Cerritos, CA
License number: PSY-14808
Stipulated decision effective: 3/20/2008
Revoked, stayed, 7 years probation.

SPINDELL, William Arden, Ph.D.
Laguna Woods, CA
License number: PSY-4890
Stipulated decision effective: 3/13/2008
Revoked, stayed, 3 years probation.

ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION FILED

Accusations are charges and allegations which still must undergo rigorous tests of proof at later administrative hearings. Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

BAJE, Ulysses Yanez, M.D.
Covina, CA
License number: A-29462
Accusation filed: 3/7/2008

CHOI, Joon, M.D.
Glendale, CA
License number: G-80351
Accusation filed: 3/20/2008

CHUNG, Theodore W., M.D.
San Gabriel, CA
License number: G-12383
Accusation filed: 3/20/2008

DREYER, Joel Stanley, M.D.
Murrieta, CA
License number: C-31198
Accusation filed: 3/13/2008

ESCOBAR, Martin, M.D.
Boardman, OH
License number: A-76852
Accusation filed: 3/7/2008

GEIGER, Kenneth Robert, M.D.
Sonoma, CA
License number: G-55346
Accusation filed: 3/24/2008

HASTIK, Karin Leslie, M.D.
San Francisco, CA
License number: A-60374
Accusation filed: 3/24/2008

LIN, Gene Washington, M.D.
San Diego, CA
License number: A-63944
Accusation filed: 3/13/2008

MABRY, Quince Lee, M.D.
La Mesa, CA
License number: G-52265
Accusation filed: 3/13/2008

REISS, Jeffrey Ronald, M.D.
Marina del Rey, CA
License number: A-36946
Accusation filed: 3/13/2008

SALAZAR, Robert Gonzales, M.D.
Fresno, CA
License number: G-42244
Accusation filed: 3/26/2008

SANNAR, Elise Michelle, M.D.
Denver, CO
License number: A-96357
Accusation filed: 3/5/2008

SCRUGGS, Ramon, M.D.
Tustin, CA
License number: G-48978
Accusation and Petition to Revoke Probation filed: 2/29/2008

VANGALA, Venkat Reddy, M.D.
Victorville, CA
License number: A-40666
Accusation filed: 3/26/2008

Physician Assistant

TURNIPSEED, Steven Duvall
Tarzana, CA
License number: PA-11867
Accusation filed: 3/27/2008

Physical Therapist

ORTIZ, Abraham, III
Loma Linda, CA
License number: PT-22645
Accusation filed: 3/25/2008

Podiatrist

TILLEY, Gregory Ernest, D.P.M.
Fullerton, CA
License number: E-2817
Accusation filed: 3/6/2008

Psychologist

SCIARONI, Brian Lloyd, Ph.D.
Fresno, CA
License number: PSY-8349
Accusation filed: 3/11/2008

AMENDED ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

BABAALI, Hossein, M.D.
Los Angeles, CA
License number: G-86162
Amended Accusation and Petition to Revoke Probation filed: 3/25/2008

CHER, John B., M.D.
Santa Monica, CA
License number: A-38966
Amended Accusation and Petition to Revoke Probation filed: 2/11/2008

KERR, Mary Campbell, M.D.
Beverly Hills, CA
License number: A-65874
Amended Accusation filed: 3/12/2008

LOUIE, Henry Wah, M.D.
Palm Springs, CA
License number: G-62393
Amended Accusation filed: 2/21/2008

MOJARAD, Mohammad, M.D.
Rancho Mirage, CA
License number: C-42082
Amended Accusation filed: 3/20/2008

PRINTZ, Louise Ann, M.D.
Napa, CA
License number: G-39032
Amended Accusation filed: 3/5/2008

ROBINSON, Harrell Edward, M.D.
Santa Ana, CA
License number: G-38954
Amended Accusation filed: 3/13/2008

ROQUE, Andrew A., M.D.
Monterey Park, CA
License number: A-19578
Amended Accusation filed: 3/13/2008

ACCUSATION WITHDRAWN OR DISMISSED

Accusation 'withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physician & Surgeon

KUTSCHBACH, Joan Zielske, M.D.
Sacramento, CA
License number: G-45803
Accusation withdrawn: 3/13/2008

Psychologists

KAPPLER, Kevin Andrew, Ph.D.
Copperopolis, CA
License number: PSY-9536
Accusation dismissed: 3/27/2008

SNYDER, Phillip David, Ph.D.
Pasadena, CA
License number: PSY-9930
Accusation withdrawn: 3/5/2008

PROBATIONARY LICENSE

Where good cause exists to deny a license, the licensing agency has the option to issue a conditional license subject to probationary terms and conditions.

Physician Assistant

REYNOSO, Roberto
Monterey, CA
License number: PA-19687
Stipulated decision effective: 3/20/2008
5 year probationary license issued: 3/26/2008

Physical Therapist Assistant

DAVIS, Willie Anthony
San Diego, CA
License number: AT-8670
Stipulated decision effective: 2/26/2008
5 year probationary license issued.

STATEMENTS OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative Law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Physicians & Surgeons

ATAEE, Shahab
Irvine, CA
License number: None
Statement of Issues filed: 3/13/2008

HADJ, Faranak Mohammad
Phillips Ranch, CA
License number: None
Statement of Issues filed: 3/24/2008

SHAH, Mahir I.
Irvine, CA
License number: None
Statement of Issues filed: 3/24/2008

Physician Assistant

WILLIAMS, Tarquin Siam
Moreno Valley, CA
License number: None
Statement of Issues filed: 3/27/2008

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Medical Board of California
Enforcement Program
Central File Room
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

MEDICAL BOARD OF CALIFORNIA
Discipline Coordination Unit

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May 2008

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- ***Physician Assistant Committee***
- ***Physical Therapy Board of California***
- ***Board of Podiatric Medicine***
- ***Board of Psychology***

DECISIONS

Physicians & Surgeons

BOHM, John Edwin
Huntington Beach, CA
License number: A-51741
Decision effective: 4/24/2008
License revoked.

BOYAJIAN, John Arthur
Boise, ID
License number: A-25855
Stipulated decision effective: 4/18/2008
Surrender of License.

CADIZ, Rolando B., M.D.
Riverside, CA
License number: A-43039
Stipulated decision effective: 4/25/2008
Public Reprimand issued.

COLLINS, Richard Scott, M.D.
Moline, IL
License number: GFE-84500
Public Letter of Reprimand
issued: 4/14/2008

COOK, Albert Paul, M.D.
Hemet, CA
License number: A-22030
Stipulated decision effective: 4/25/2008
Revoked, stayed, 35 months probation.

CRAGEN, Richard Darin
Temecula, CA
License number: A-54872
Stipulated decision effective: 4/21/2008
Surrender of License.

DAVOODIFAR, Susan, M.D.
Irvine, CA
License number: A-62141
Stipulated decision effective: 10/9/2006
Public Letter of Reprimand
issued: 4/8/2008

DYKES, John R., II
Grand Blanc, MI
License number: G-87794
Decision effective: 4/25/2008
License revoked.

GALYON, Steven Wayne, M.D.
Sidney, MT
License number: A-82784
Public Letter of Reprimand
issued: 4/22/2008

GEIGER, Kenneth Robert
Sonoma, CA
License number: G-55346
Stipulated decision effective: 4/2/2008
Surrender of License.

GOODARZI, Mashallah, M.D.
Los Angeles, CA
License number: A-33411
Stipulated decision effective: 4/6/2006
Public Reprimand issued: 4/18/2008

GORYL, Gerard Geoffrey, M.D.
Redondo Beach, CA
License number: A-42265
Stipulated decision effective: 6/19/2006
Public Reprimand issued: 4/23/2008

KARLIN, Michael Robert
Naples, FL
License number: G-54678
Surrender of License: 4/21/2008

KROUPA, Vladimir, M.D.
Porterville, CA
License number: A-48466
Stipulated decision effective: 4/7/2008
Public Reprimand issued.

MURRAY, David Bardwell
Whittier, CA
License number: A-21805
Stipulated decision effective: 4/4/2008
Surrender of License.

NISHIBAYASHI, Steven Wayne, M.D.
Glendale, CA
License number: G-38552
Public Letter of Reprimand
issued: 4/17/2008

TATARIN, Rudiger Karl, M.D.
Orange, CA
License number: A-39779
Stipulated decision effective: 4/9/2008
Revoked, stayed, 35 months probation.

TIMBADIA, Ela Mansukhlal, M.D.
Glendale, AZ
License number: A-46384
Public Letter of Reprimand
issued: 4/23/2008

TREASURE, Trevor Edward
Carmel, IN
License number: A-60364
Surrender of License: 4/21/2008

WINKLER, Heidi Ann, M.D.
Norwalk, CA
License number: A-50311
Stipulated decision effective: 4/7/2008
Revoked, stayed, 7 years probation.

Physician Assistant

COLEMAN, John Lee
Yucca Valley, CA
License number: PA-13693
Decision effective: 4/17/2008
License revoked.

Physical Therapist

SCHILLING, Erin Maria
Culver City, CA
License number: PT-25459
Stipulated decision effective: 4/11/2008
Revoked, stayed, 5 years probation.

ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION FILED

Petitions to Revoke Probation are filed when a licensee is charged with a violation of a prior disciplinary decision.

Physicians & Surgeons

ALDANA, Daniel Herman, M.D.
Irvine, CA
License number: G-80094
Accusation filed: 4/24/2008

ANDREWS, Thomas James, M.D.
Redding, CA
License number: G-79955
Accusation filed: 4/2/2008

ANG, Eriberto C., Jr., M.D.
Huntington Park, CA
License number: A-42030
Accusation filed: 4/21/2008

BOOTH, Geoffrey Allan, M.D.
Santa Barbara, CA
License number: A-74560
Accusation filed: 4/15/2008

FAYAZ, Imran, M.D.
The Woodlands, TX
License number: A-67748
Accusation filed: 4/4/2008

MCINTYRE, Robert C., M.D.
Twain Harte, CA
License number: A-20692
Accusation filed: 4/16/2008

NGUYEN, Li Quang, M.D.
Westminster, CA
License number: G-63837
Accusation filed: 4/8/2008

O'NEILL, Mary M., M.D.
San Jose, CA
License number: G-69694
Accusation filed: 4/18/2008

RAOOF, Tooraj, M.D.
Encino, CA
License number: A-42698
Accusation filed: 4/2/2008

SALINGER, David L., M.D.
Olympic Valley, CA
License number: G-59234
Accusation and Petition to Revoke Probation filed: 4/10/2008

SLAY, Robert Duncan, Jr., M.D.
Palos Verdes Estates, CA
License number: G-31037
Accusation filed: 4/10/2008

Physician Assistants

DAY, Sandra Jean
Marysville, CA
License number: PA-17878
Accusation filed: 4/11/2008

JOHNSON, Kenji Lamont
Pasadena, CA
License number: PA-16862
Accusation filed: 4/11/2008

Physical Therapist

NEWCOMB, Jennifer Jill
Orlando, FL
License number: PT-26658
Accusation filed: 4/24/2008

AMENDED ACCUSATIONS AND/OR PETITIONS TO REVOKE PROBATION FILED

Physicians & Surgeons

BORCHERS, Doyle John, III, M.D.
Stanford, CA
License number: A-64879
Amended Accusation filed: 4/22/2008

DUNN, James Sandidge, Jr., M.D.
Porterville, CA
License number: A-84568
Amended Accusation filed: 4/15/2008

EDISON, Richard Bruce, M.D.
Fort Lauderdale, FL
License number: G-39624
Amended Accusation filed: 4/4/2008

GILLIAN, Terry Allen, M.D.
Fresno, CA
License number: A-29523
Amended Accusation filed: 4/27/2007

LUNG, Roy Chi Wing, M.D.
Fountain Valley, CA
License number: A-53998
Amended Accusation filed: 4/15/2008

MILLER, Stephen P., M.D.
Houston, TX
License number: G-16153
Amended Accusation filed: 4/10/2008

OURIAN, Siamak, M.D.
Beverly Hills, CA
License number: A-65201
Amended Accusation filed: 4/11/2008

TAYLOR, Ursula Elisabet, M.D.
Los Angeles, CA
License number: A-55572
Amended Accusation filed: 3/28/2008

TRAN, Thanh Ngoc, M.D.
Huntington Beach, CA
License number: A-40326
Amended Accusation filed: 4/23/2008

UWAYDAH, Munir, M.D.
Redondo Beach, CA
License number: A-62059
Amended Accusation filed: 4/16/2008

Psychologist

RAND, Randy, Ph.D.
Mill Valley, CA
License number: PSY-12137
Amended Accusation filed: 4/24/2008

ACCUSATIONS WITHDRAWN OR DISMISSED

Accusation 'withdrawn" means the formal charges were dropped before the matter went to an administrative hearing. Accusation "dismissed" means the matter went to litigation and the respondent/licensee prevailed either at the administrative level or at the judicial level.

Physicians & Surgeons

GARCIA, Fernando Dominguez, M.D.
Visalia, CA
License number: A-37360
Accusation withdrawn: 4/11/2008

SOLONIUK, Leonard Joel, M.D.
Redding, CA
License number: G-48518
Accusation withdrawn: 4/29/2008

ZWASS, Josef Benjamin, M.D.
Carlsbad, CA
License number: G-62469
Accusation withdrawn: 4/24/2008

STATEMENT OF ISSUES FILED

When an applicant for licensure is informed the license will be denied for cause, the applicant has a right to request a formal hearing, usually before an Administrative law Judge. This process is initiated by the filing of a Statement of Issues, which is similar to an Accusation.

Physician Assistant

GONZALEZ, Ramon Castellon
Downey, CA
License number: None

Statement of Issues filed: 4/17/2008

Psychologist Assistant

REYNOLDS, Lisa Marie
Signal Hill, CA
Registration number: None
Statement of Issues filed: 4/30/2008

STATEMENT OF ISSUES DECISION

Physician & Surgeon

CASTELLANOS, Andrew John
Cerritos, CA
License number: None
Decision effective: 4/2/2008
License denied.

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Medical Board of California
Enforcement Program
Central File Room
2005 Evergreen Street
Sacramento, CA 95815

Your complaint has been sent for investigation.

■ *WHY IS MY COMPLAINT BEING REFERRED FOR INVESTIGATION?*

Your complaint is being referred for investigation because the Board believes there may be evidence to show that a violation of the Business and Professions Code has occurred. If proven, the violation may warrant some kind of disciplinary measure.

■ *WHAT KINDS OF COMPLAINTS WARRANT A FORMAL INVESTIGATION?*

In general, any complaint that would warrant disciplinary action if substantiated (e.g., sexual misconduct, gross negligence and/or incompetence, etc.) is referred for investigation. Other kinds of complaints may also require a formal investigation. These include physician impairment, unprofessional conduct and unlicensed practice issues.

■ *WHAT HAPPENS WHEN THE DISTRICT OFFICE RECEIVES MY COMPLAINT?*

Complaints are referred to one of the Board's District Offices based on geographic location. The supervising investigator reviews the case and assigns it to an investigator. The investigator, and perhaps the supervisor, determines the proper investigative steps required to thoroughly investigate the complaint.

Complaints alleging negligence that involve patient death or serious bodily injury are given the highest priority. In addition, complaints alleging physician impairment, sexual misconduct or complaints which present immediate concern about patient harm, i.e., injury or death, are considered "high priority cases" and are given priority handling. Investigators are peace officers and have the authority to pursue criminal and administrative violations of the law.

■ *WHEN WILL I BE CONTACTED?*

The Board considers all complaints important. Many complaints, however, present an immediate threat to public safety and must be given priority. The investigation of your complaint will be conducted in as timely a manner as possible. You will be contacted once the complaint has been assigned to an investigator and the investigative process has begun. Additional information should be held until that time; however, the Board should be notified in writing of any address and telephone number changes.

■ *HOW IS THE INVESTIGATION CONDUCTED?*

Investigative steps may include, but are not limited to the following:

- Obtaining medical records or other information/evidence
- Locating and interviewing the complainant, any witnesses, and the physician
- Obtaining expert review of the case
- Drafting and serving investigational subpoenas
- Inspecting the location where the allegations occurred
- Executing search warrants
- Conducting undercover operations

In general, after information is collected and compiled and the complainant has been interviewed, the investigator, and perhaps the supervisor or a medical consultant, interviews the physician to discuss the details of the complaint and ask questions.

Quality of care issues are then reviewed by a medical expert. The standard of proof for administrative cases is "clear and convincing evidence to a reasonable certainty," a much higher standard than for civil litigation cases. This can be a very challenging when pursuing a complaint because administrative charges must be proven before an administrative law judge who uses this higher and more difficult standard.

If the investigation does not support a violation of the law, the complaint is closed. Also, if the evidence obtained in the investigation shows a violation occurred, but the violation is insufficient to support administrative action, the case is closed and maintained on file for future reference. The investigator will notify the complainant and the physician by telephone or in writing of the disposition of the complaint.

If the investigation reveals sufficient evidence of violations of the Medical Practice Act or other laws which would warrant discipline against the license, the case will be referred to the Office of the Attorney General (AG), Health Quality Enforcement Section, for administrative action.

■ *WHAT HAPPENS DURING THE DISCIPLINE PROCESS?*

When an investigation is completed, the case is reviewed by the supervising investigator and a representative from the AG's office who will determine whether sufficient evidence exists to support sending the case to the AG's office. The decision about what charges may be filed is based on a review of the evidence obtained and a determination by the AG's office about which charges can be substantiated by the evidence.

The AG's office determines if an accusation or petition to compel competency, psychological, or physical examination should be filed. Since every case is unique, the Medical Board and the AG's office will determine the most reasonable and appropriate method to ensure public protection. This process can be complicated and lengthy. Further questions should be directed to the assigned investigator. If the AG's office rejects the case, it will be closed and the complainant will be notified. Again, if future complaints of a similar nature are received, the earlier complaint may be considered further.

■ *IS THE INVESTIGATION CONFIDENTIAL?*

Details of the complaint and investigation remain confidential and are not public record; however, the complaint must be discussed with the physician.

■ *DO I HAVE PROTECTION FROM CIVIL LITIGATION?*

From time to time, patients express concern about the potential for a lawsuit resulting from the initiation and/or participation in an investigation. Civil Code Section 47 provides some protections against a lawsuit, and this issue can be further discussed with the assigned investigator. A copy of this section of law can be obtained from your local library or on the Internet at www.leginfo.ca.gov.

■ *WHERE ARE THE DISTRICT OFFICES?*

■ *Cerritos*	*562-402-4668*
■ *Diamond Bar*	*909-396-5305*
■ *Fresno*	*559-221-0558*
■ *Glendale*	*818-551-2117*
■ *Pleasant Hill*	*925-937-1900*
■ *Rancho Cucamonga*	*909-476-4036*
■ *Sacramento*	*916-263-2585*
■ *San Bernardino*	*909-383-4755*
■ *San Diego*	*858-467-6830*
■ *San Jose*	*408-437-3680*
■ *Tustin*	*714-247-2126*

MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit
1426 Howe Avenue, Suite 54
Sacramento, CA 95825

■ **To discuss your complaint, call:**

1-800-633-2322
or 916-263-2424
Fax: (916) 263-2435
TDD: (916) 263-0935

■ **To check on a specific doctor, call our Consumer Information Unit:**

916-263-2382

■ **Or visit our Web site:**

www.medbd.ca.gov

The mission of the Medical Board of California is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

3/03

QUESTIONS AND ANSWERS ABOUT INVESTIGATIONS

Central Complaint Unit

Medical Board of California

the state agency that licenses medical doctors, investigates complaints, and disciplines those who violate the law

Your complaint has been referred to a Board medical consultant.

■ *WHAT IS A MEDICAL CONSULTANT?*

Medical consultants are licensed physicians in good standing who are in practice or employed in the field of medicine in the community. They provide their services to the Board on a part-time contract basis to review quality of care complaints.

■ *WHAT IS THE MEDICAL CONSULTANT'S ROLE?*

The medical consultant's role is to determine whether the care and treatment provided was within the "standard of practice." The medical consultant may not address every question/concern that you have; however, the overall care and treatment will be thoroughly reviewed.

■ *HOW LONG IS THE REVIEW PROCESS?*

Normally, the required time for reviewing your complaint may range between four and six weeks. However, if additional information is requested by the medical consultant, the process could take longer.

■ *WILL I HAVE AN OPPORTUNITY TO DISCUSS MY COMPLAINT WITH THE MEDICAL CONSULTANT?*

No. Due to the high volume of complaints reviewed by the medical consultants, it is not feasible for a medical consultant to discuss your complaint on an individual basis.

■ *IS IT A CONFLICT OF INTEREST TO HAVE A MEDICAL CONSULTANT REVIEW OTHER PHYSICIANS' DIAGNOSES AND TREATMENT?*

No. In order to evaluate whether the treatment provided by a physician was appropriate, another physician must be consulted. The medical consultant provides an informed, objective opinion about the "standard of practice" and explains why the treatment was appropriate or inappropriate.

■ *WHAT TYPE OF COMPLAINTS DO MEDICAL CONSULTANTS REVIEW?*

They may be asked to review issues such as:

- Diagnosis and treatment
- Excessive or illegal prescribing
- Dishonesty (fraudulent claims or excessive treatment)
- Inappropriate examinations

■ *WHAT ARE MEDICAL CONSULTANTS LOOKING FOR WHEN REVIEWING COMPLAINTS?*

By reviewing and evaluating complaints and copies of patients' medical records, the medical consultants, drawing upon their expertise in the field of medicine, can determine whether there is any evidence that might substantiate a complaint of:

- **Gross negligence** (*an <u>extreme</u> departure from the standard of practice*): physicians failing to do basic diagnostic tests, not recognizing or acting on common symptoms, not using accepted effective treatments or diagnostic procedures, using outdated procedures, not referring a patient to a specialist when appropriate.

- **Negligence** (*a <u>simple</u> departure from the standard of practice*): negligent acts that are not an extreme departure.

One act of simple negligence usually is not enough to take formal action against a doctor's license. However, patterns of repeated negligent acts may be sufficient grounds in some cases.

- **Incompetence** (*a lack of knowledge or ability in discharging professional medical obligations*): a physician who is unable to recognize and act appropriately on symptoms would be considered incompetent.

■ *AM I ENTITLED TO COPIES OF MY MEDICAL RECORDS FROM THE MEDICAL BOARD?*

You may request copies of your medical records by submitting a written request to your doctor.

Pursuant to Government Code Section 6254(f), Medical Board of California records pertaining to complaints and investigation are exempt from public disclosure. Therefore, a copy of the medical consultant's report will not be available to the complainant.

By law, all records that are part of the Board's investigation become the property of the Board and cannot be released to anyone.

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By law, all records that are part of the Board's investigation become the property of the Board and cannot be released to anyone.

■ *WHAT HAPPENS AS A RESULT OF THE MEDICAL CONSULTANT'S REVIEW?*

- If no violation of the Medical Practice Act has been confirmed, the case will be closed and maintained on file for one year.
- If a violation is found but does not constitute grounds for disciplinary or administrative action against the physician's license, the case is closed and maintained on file for five years.
- If the medical consultant determines the information/medical records provide evidence of possible gross negligence and/or evidence of significant violation of the Medical Practice Act, the complaint will be forwarded to one of the Board's District Offices for further investigation. A second review by a physician expert will be conducted at that time.
- In all of the above situations, you will be notified, usually by letter, of the medical consultant's finding and the outcome.

California Law imposes a very high burden of proof upon the Medical Board by requiring that we establish "clear and convincing evidence to a reasonable certainty" that a violation of the law occurred before administrative action can be taken. This is a much higher standard than for civil litigation cases.

MEDICAL BOARD OF CALIFORNIA

Central Complaint Unit
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03/03

MOST ASKED QUESTIONS ABOUT MEDICAL CONSULTANTS

Central Complaint Unit

Medical Board of California

the state agency that licenses medical doctors, investigates complaints, and disciplines those who violate the law

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2382 FAX (916) 263-2567
www.mbc.ca.gov

NOTIFICATION OF NAME CHANGE

Please indicate license type below:

Physician & Surgeon ☐
Midwife ☐
Spectacle Lens Dispenser/Contact Lens Dispenser ☐

FOR OFFICE USE ONLY

Date Received: _____

Enforcement Approval: ____Yes ____No

Date: _____

IMPORTANT: The first line of the declaration MUST indicate the name you used prior to your name change.

DECLARATION

I, _____ _____ _____ (name prior to change)
(First) (Middle) (Last)

hereby certify that I was **originally issued and currently hold** license/registration

number(s) _____ to practice in the State of California.

I further certify I have assumed the name of:

_____ _____ _____
(First) (Middle) (Last)

based on one of the following:

Court Order ○ Marriage ○ Naturalization ○ Dissolution of Marriage ○

_____

I hereby declare under penalty of perjury under the laws of the State of California that this is my new adopted name for all purposes, and this name change has not been made for fraudulent purposes.

You **MUST** submit a certified copy of the following documents where applicable. If a photocopy of the certified copy is submitted, it must be notarized. Submit this form to the Medical Board of California at the address shown above:

- Marriage Certificate
- Final Dissolution Decree
- Copy of Court Order
- Naturalization Certificate

This notification will not generate a duplicate certificate. Please submit an application for a duplicate license, if you wish a certificate reflecting this name change.

BOTH PAGES OF THIS FORM MUST BE COMPLETED.

PHOTO AREA PASTE A 2" X 3" PHOTO HERE PHOTO MUST BE RECENT AND MUST BE OF YOUR HEAD & SHOULDER AREAS ONLY SCANNED, ALTERED, OR POLAROID PHOTOS ARE NOT ACCEPTABLE.	PHOTO DECLARATION I hereby declare under penalty of perjury under the laws of the State of California that the photo of me attached hereto, was taken on or about _____. Applicant's Signature: _____

TELEPHONE NUMBER

_____

CURRENT ADDRESS OF RECORD (PUBLIC/MAILING ADDRESS)

Address: _____

_____

City: _____ State: _____ Zip: _____

This is the address that will be displayed on your profile on the Board's Internet Web site. If listing a PO Box, you must also provide a confidential street address.

Confidential Street Address:

Address: _____

_____

City: _____ State: _____ Zip: _____

NOTICE: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will result in the application being rejected as incomplete. The information provided will be used to identify the licensee and to verify the licensee's identification under Section 2081of the Business and Professions Code. Licensees have the right to review their application file subject to the provisions of the Information Practices Act. The Licensing Program Chief is the custodian of records. Information in this application may be transferred to other governmental and law enforcement agencies.

AFFIDAVIT

I certify under penalty of perjury under the laws of the State of California that the information provided on this form, including supporting documentation and photograph of me, is true and correct and that I am licensed/registered to practice in the State of California.

_____ _____

Applicant's Signature Date

NOTARY

This individual, _____, has appeared before me, signed in my presence and is identified as the above individual. Subscribed and sworn to before me this _____ day of _____, _____.

_____ _____

Notary Public's Signature Telephone Number

Address _____

My commission expires _____. SEAL

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2424 FAX: (916) 263-2435
www.mbc.ca.gov

REQUEST FOR COPY OF 805 REPORT

(Pursuant to Business & Professions Code 805.5)

Requestor Information

Is the requesting entity an LVS user? If yes, enter Facility Login _____

If **not**, indicate the type of requesting entity:

☐ Health care facility licensed by California Dept. of Health Services (H&S Code Div. 2, § 1200)
PLEASE ATTACH A COPY OF THE LICENSE ISSUED

☐ Health care service plan licensed by Dept. of Managed Health Care - enter license # _____

☐ Medical care foundation

☐ Other _____

Name of requesting entity: _____

Mailing address: _____

_____

Medical staff person (& title) requesting copy: _____

Phone #: _____ Fax #_____
(Copies will be faxed on an emergency basis ONLY.)

Requested Information

Physician's name (Last, First, MI)	**California medical license #**

Medical Board Response (for Medical Board use ONLY)

Date returned to requestor: _____

☐ A copy of the 805 report(s) as requested above is attached.

☐ There are no 805 reports on file with the Medical Board as of this date for this physician.

☐ Your request cannot be granted:

You have not provided proof that you are entitled to receive copies of 805 reports (see reverse).

The requesting facility is not licensed by DHS or DMHC as required (see reverse).

The requesting facility is not a medical care foundation.

The request lacks sufficient information as follows: _____.

For additional information, please contact Keith DeGeorge at (916) 263-2449.

Section 805.5 California Business and Professions Code

(a) Prior to granting or renewing staff privileges for any physician and surgeon, psychologist, podiatrist, or dentist, any health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, or any health care service plan or medical care foundation, or the medical staff of the institution shall request a report from the Medical Board of California, the Board of Psychology, the Osteopathic Medical Board of California, or the Dental Board of California to determine if any report has been made pursuant to Section 805 indicating that the applying physician and surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his or her staff privileges restricted as provided in Section 805. The request shall include the name and California license number of the physician and surgeon, psychologist, podiatrist, or dentist. Furnishing of a copy of the 805 report shall not cause the 805 report to be a public record.

(b) Upon a request made by, or on behalf of, an institution described in subdivision (a) or its medical staff, which is received on or after January 1, 1980, the board shall furnish a copy of any report made pursuant to Section 805. However, the board shall not send a copy of a report (1) if the denial, removal, or restriction was imposed solely because of the failure to complete medical records, (2) if the board has found the information reported is without merit, or (3) if a period of three years has elapsed since the report was submitted. This three-year period shall be tolled during any period the licentiate has obtained a judicial order precluding disclosure of the report, unless the board is finally and permanently precluded by judicial order from disclosing the report.

In the event a request is received by the board while the board is subject to a judicial order limiting or precluding disclosure, the board shall provide a disclosure to any qualified requesting party as soon as practicable after the judicial order is no longer in force. In the event that the board fails to advise the institution within 30 working days following its request for a report required by this section, the institution may grant or renew staff privileges for the physician and surgeon, psychologist, podiatrist, or dentist.

(c) Any institution described in subdivision (a) or its medical staff that violates subdivision (a) is guilty of a misdemeanor and shall be punished by a fine of not less than two hundred dollars ($200) nor more than one thousand two hundred dollars ($1,200).

Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
CENTRAL COMPLAINT UNIT
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2424 FAX (916) 263-2435
www.mbc.ca.gov

OUTPATIENT SURGERY – PATIENT DEATH REPORTING FORM

State law (Section 2240 (a) of the California Business and Professions Code) requires that whenever a patient death results from a scheduled medical procedure outside of a general acute care hospital, either by the physician or by a person acting under the physician's orders or supervision, the physician must complete this form and send it to: Medical Board of California, 2005 Evergreen Street, Sacramento, CA 95815, Attn: Central Complaint Unit

1. Patient Name:

Last_____ **First**_____ **Middle**_____

Address:_____ Date of Birth:_____
Number Street City State ZIP Code

Medical Record Number:_____ Physical Location of Medical Record:_____

2. Name of physician who performed surgery:

Last_____ **First**_____ **Middle**_____

2a. Physician's practice specialty and ABMS certification:_____
2b. Physician's license number:_____

3. Surgery Date:_____
3a. Patient Identifier (Social Security Number, Patient ID Number, etc.):_____

4. Name and address of outpatient setting where surgery/outpatient procedure was performed:

Name_____

Address:_____
Number Street City State ZIP Code

5. Outpatient setting is licensed, certified, and/or accredited by:
   a.
   b.
   c.

6. Type(s) of outpatient procedures performed:

7. Circumstances of patient's death: (please attach additional sheets if necessary)

8. Name and location of hospital or emergency center where patient was transferred: (a separate **Patient Transfer Form** must also be completed)

9. Date of Report:_____ Physician Completing this Form:_____
(Please Print Legibly)

PATIENT TRANSFER REPORTING FORM

(Pursuant to Business and Professions Code Section 2240)

1. Name of Patient's Outpatient Setting Physician:
Last _____ **First** _____ **Middle**
Physician's License Number:

2. Name of Physician with Hospital Privileges (if the same as above, leave blank):
Last _____ **First** _____ **Middle**
Physician's License Number:

Medical Record Number: _____

3. Patient Name:
Last _____ **First** _____ **Middle**

Address: _____ Date of Birth: _____
Number Street City State ZIP Code

3a. Patient Identifier (Social Security Number, Patient ID Number, etc.):

4. Name and Address of Hospital or Emergency Center where Patient was Transferred:

State law (Section 2240(b) of the California Business and Professions Code) requires that a completed copy of this entire form be placed in a patient's file. After completing the form, make 2 photocopies of the full form. Send 1 copy to the facility identified in #4 above for insertion in the patient's record. With the second copy, cut on line and mail the bottom portion within 15 days of the transfer to:

Office of Statewide Health Planning and Development
Patient Data Section
Attn: Physician Reporting-Transfers
400 R Street, Suite 270
Sacramento, CA 95814

As of January 1, 2002 per B&P Code 2240, this form should be mailed to the Office of Statewide Health Planning and Development.

✂----------

5. Specific Procedure(s) Performed:

5a. _____ Sex of Patient _____ Age of Patient _____ County of Surgical Setting

6. Transfer for postoperative care was planned and arranged with hospital prior to surgery: ____ yes ____ no

6a. Events triggering/necessitating transfer (including pre-arranged post operative care): ____ respiratory distress ____ drug reaction ____ cardiovascular distress ____ excessive bleeding ____ other (please specify)

Details of event (Please attach explanation if more space is needed and include in patient's chart and mailing to the Office of Statewide Health Planning and Development).

7. Duration of Hospital Stay:
____ Day(s) ____ Week(s) ____ Month(s)

8. Final Disposition: ____ Patient Died
_____ Patient Sent Home ____ Other (please specify)

9. Physician Practice Specialty and ABMS Certification:

Date of Report: _____

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

CENTRAL FILE ROOM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2525 FAX (916) 263-2420
www.caldocinfo.ca.gov

Please complete Section I to request public documents.

I. Requestor Information

Name: _____ Telephone No.: _____

Address: _____ Fax: _____

_____ E-mail: _____

Check here if you are a government agency ☐
Government Agency Name: _____
Check here if you are requesting certified public documents ☐ (Additional charge of $2.00 per document will be assessed.)

Public Information Regarding:

Physician's Full Name: _____

Physician's License Number (if known): _____

Please notify me of payment information by (check one):

☐ Mail ☐ Fax ☐ E-mail

Section II will be completed by Medical Board of California staff and returned to you for submission of payment.

II. Document Information

For MBC use only:

Cost of public documents: _____

Cost of certification: _____

Total Cost: _____

File number: _____

III. Please mail payment and this completed *form* to:

Medical Board of California
Attn: Central File Room
P.O. Box 255729
Sacramento, CA 95865-5729

Lumetra
Brighter insights. Better healthcare.

Appendix VIII: Other States

- Massachusetts Board of Registration in Medicine Patient Care Assessment (PCA) Division: Instructions for Completing Safety and Quality Review Form
- Chart outlining each state's existing statute or legislation and PSO, reporting requirements, and pending legislation
- Federation of State Medical Boards: 2008 Legislative Services Update

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE PATIENT CARE ASSESSMENT (PCA) DIVISION

INSTRUCTIONS FOR COMPLETING SAFETY AND QUALITY REVIEW FORM

(revised 6/07)

General Instructions

The Safety and Quality Review (SQR) Form replaces the Major Incident Report form. This is the prescribed form for reporting events that meet PCA "major incident" reporting requirements under 243 CMR 3.08. The information that you provide in the SQR is protected by statute from public disclosure. (Please see M.G.L .c. 111, §204 and 205.). The information is also not shared with the Board's Enforcement Division, Data Repository Unit or any other parts of the Board that oversee the practice of physicians licensed in Massachusetts. You are not required to submit the names of physicians involved in the reported events

The decision whether an events meets PCA reporting requirements often is challenging because the regulatory language requires that the facility determine the degree of seriousness of the event and the patient's outcome. (See 243 CMR 3.08). PCA Division staff is available for consultation should you have any questions about whether to report a certain unexpected event. Please review and complete all sections of the SQR. The form can be downloaded from the Board's website and completed online at: www.massmedboard.org/pca. However, it is not yet possible to submit the form online. The original signature of the reporter is required on the form submitted to the PCA Division. Faxes are not accepted. If you have questions about whether to report an event or completing the reporting form, call the Board's PCA Division at (617) 654-9855.

Section I. Report Identification

Indicate whether you are submitting an initial or a follow-up SQR. The same form is used for both. If you are completing a follow-up report, be sure to indicate the date on which you submitted the initial report.

SQRs must be submitted to the Board's PCA Division on a quarterly basis, i.e., you must submit an initial SQR no later than 30 days following the quarter in which the unexpected event occurred. Some facilities will not have completed their internal reviews of the event or taken all appropriate corrective actions or performance improvement measures within this time frame. If this is the case and a report is due, you should submit an initial SQR without waiting until your internal review is completed. When submitting the initial report, you should indicate in Section VIII that the investigation is still open and provide the date on which you believe the review will be completed. When the review has been completed, you must submit a follow-up report and provide any information that was not available at the time of the initial report.

You may submit as many follow-up reports as needed. However, please do not wait to submit a follow-up report until the PCA Division contacts you and requests it—you are responsible for submitting a follow-up report as soon as your facility's internal review has been completed. If you implement additional safety or performance improvement measures after submitting the first follow-up report, or you need to update the PCA Division on any other information pertaining to the event, please submit another follow-up report.

Section II. Reporting Health Care Facility

It is the responsibility of the facility's PCA Coordinator to ensure that the SQR is complete and submitted in a timely fashion. If the PCA Coordinator does not have a clinical background, sections VII (Nature of Event); VIII (Internal Review); and IX (Safety and Quality Improvement Measures) must be completed by someone who does. If a committee serves as the PCA Coordinator, the person completing the form should be a member of that committee and have a clinical background.

More than one health care facility may be responsible for submitting a SQR about the same event. Under some circumstances, a facility is

responsible for reporting an event that may not have occurred on the premises but nonetheless originated at the institution. If, for example, a patient underwent an ambulatory procedure at your facility, was discharged, and died later at home or at another facility, the PCA Division expects that your quality assurance program would (or should) learn of the event, review the care your facility delivered to the patient and report the case. The same would apply, for example, to a delivery that took place at your facility after which the mother died at another institution from a cause related to the delivery.

In such cases, it is often through the patient's attending physician that a facility becomes aware of the unexpected outcome. Attending physicians should be aware of their responsibility to inform the PCA Coordinator of these events.

Section III. Date and Location of Event

Location code information is supplied via a drop-done menu on the form. If the event occurred somewhere that is not listed, please select "Other," and indicate the location in the specified location.

Section IV. Patient Involved in the Event

This section lists basic demographic information that PCA uses to track cases internally. In most cases, you will be providing the patient's date of admission. Health care facilities that normally do not "admit" patients (e.g., clinics) should indicate the patient's date of presentation. Presentation date should also be used by facilities in cases where the patient was not admitted but was seen by staff. These cases often involve the emergency room, e.g., a patient death that occurs in the emergency room; a transfer of a patient from the emergency room to another facility; or an event occurring at a patient's home or en route to or from the hospital after s/he was "discharged" from the emergency room. If multiple patients were involved in the event, please fill out a separate report for each patient.

Please select the most appropriate category from the drop-down bar when indicating race/ethnicity.

Section V. Facility Staff Involved in Event

Health care provider names are not required. The information you provide in this section is not used for disciplinary purposes but to ensure that your PCA program has a process for identifying and addressing individual health care provider issues. This information is confidential and not shared by the PCA Division with the Board's Enforcement Division, Data Repository Unit or other areas of the Board that oversee the practice of individual physicians licensed in Massachusetts.

The specialty of the provider and his or her relationship to the patient is provided in the drop-down bars.

Section VI. Type of Event

On the reporting form, check the box for the appropriate "type" of "major incident" that took place. If the event is either a Type 3 or Type 4 Event, indicate whether the patient died, or suffered a major or permanent impairment of bodily function. We define "major or permanent impairment" as a significant change in the patient's functional status, either physically or mentally. If none of these three choices apply, indicate "other" and provide a brief explanation. You should base your selection on what you know about the patient's condition at the time you are completing the report.

We are tracking our SQRs to determine how many describe events that would be considered Serious Reportable Events in Health Care ("Never Events") as identified and published by the National Quality Forum. The most recent list of NQF Serious Reportable Events, are available at the HHS website: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1863. If the event that you are reporting would be considered a "Never Event," please indicate the type of "Never Event," (e.g., surgery performed on the wrong body part).

VII. Nature of Event

Basis codes can be found at Table III (attached). Select the basis code(s) that best describe(s) the nature of the event. Choose as many as apply, but

no more than ten.
In section B, Narrative Description of Event, please provide a brief one paragraph (or less) summary of the event. In section C, we ask you to please submit as an attachment (in the PDF version) a more detailed narrative of the event, which should include all relevant clinical information. When describing an event, keep in mind that the report will be analyzed by physicians, nurses and others with a clinical background. While knowledgeable in a range of clinical issues, these analysts do not know anything (at least initially) about the patient or the events leading up to the unexpected event other than what you include in the narrative description. You therefore need to describe the event as fully and completely as possible, answering the basic question of "what happened?" Other information to provide, if applicable, includes the patient's condition prior to medical intervention or treatment, a description of the intervention or treatment, and the patient's subsequent condition. While the PCA Division's review of the event is directed more to your facility's response to the event than to the event itself, it is difficult to evaluate the response without understanding what happened to the patient. It is usually better to err on providing too much information rather than too little. Please do not copy and paste the patient's discharge summary, operative reports or other parts of the medical record into this section.

Section VIII. Internal Review

If the internal review is still open at the time of the initial report, please provide the date (even if it is only approximate) on which the review is scheduled to be completed. Once it is completed, be sure to submit the results of the review in a follow-up SQR.
In section B, please indicate the titles of individuals or names of committees who were involved in the review of the event (names are not required).
In section C, please describe the results of your facility's internal review of the event in an attachment to the report. The primary focus of the PCA Division's review of the SQR is to evaluate the thoroughness and completeness of the facility's internal review of an unexpected patient outcome. This section should summarize the internal review process and provide a complete description of the results of the internal review. Information should include the areas or issues that were examined (including medical care, nursing care, pharmacy and all systemic processes) and determinations made about the ultimate cause of the patient's outcome. Ultimate conclusions regarding the quality of care delivered to the patient and whether the event could have been prevented should be provided. However, regardless of whether or not the event was determined to be preventable, the facility should describe all factors that may have caused or contributed to the patient's unexpected outcome. Please include the results of the facility's review of both systems and individual health care provider issues.

Section IX. Safety and Quality Improvement Measures

Section A asks you to please select the types of safety and quality improvement measures (including "corrective actions," if any), that were taken during the course of the review. Please select as many categories as apply. Section B asks you to use as much space as you need in an attachment (in the PDF version) to describe the measures taken by your facility.
The PCA Division expects that a facility review of an unexpected patient outcome will result in the identification of opportunities to improve care for future patients. This would include, for example, system changes or improvements, implementation of new policies or changes to existing policies; staff education, training or other actions to improve individual health care provider performance. Referral of a matter to another committee or department for additional review is not a safety or performance improvement measure. That referral is part of the facility's internal review and should be described in Section VIII, above; the results of that review should be described in this section.
If the facility's investigation is not yet complete at the time of the initial report, you may need to submit one or more follow-up reports to complete this section in order to provide information on all actions taken or to include updated information on an already described action.
If policies, procedures or protocols were changed as a result of the event, these materials should be included as an attachment to the report. Please

list the Attachments in Section XI. It is helpful to know how new policies or procedures differ from those that were in place at the time of the event- either explain how the revised procedures differ from the old or submit copies of the old and new, highlighting the changes.

Section X. Credentialed Health Care Provider Data and Findings

When applicable, please provide performance data and analysis for involved credentialed health care providers. For guidance on what to submit in this section, please see the PCA Guidelines for Collection, Analysis and Reporting of Performance Data at the following link: http://www.massmedboard.org/pca/pca_updates.shtm.

Section XI. Attachments

Please indicate if you have attached a detailed description of the event, the results of the Internal Review, Corrective Actions or Safety and Quality Improvement Measures, and the credentialed Health Care Provider Data (if applicable). Please also list or describe any additional attachments that you are submitting with the report.

R380. Health, Administration.
R380-200. Patient Safety Sentinel Event Reporting.
R380-200-1. Purpose and Authority.

(1) This rule establishes a patient safety sentinel event reporting program. It requires certain health care facilities to report serious patient injuries and to allow an independent, external review of and response to the thoroughness and credibility of the processes of investigating and responding to these events. The reporting under this rule will also help the Department and health care providers to understand patterns of failures in the health care system and to recommend statewide resolutions. It limits access to identifiable health information that facilities report to the Department under this rule.

(2) This rule is authorized by Utah Code Subsections 26-1-30(2)(a), (b), (d), (e), and (g) and Section 26-3-8.

R380-200-2. Definitions.

"Contaminated" means contamination that can be seen with the naked eye, or with use of detection mechanisms in general use, as they become reported or known to the health care facility.

"Facility" means a general acute hospital, critical access hospital, ambulatory surgical center, psychiatric hospital, orthopedic hospital, rehabilitation hospital, chemical dependency/substance abuse hospital or long-term acute care hospital as those terms are defined in Title 26, Chapter 21.

"Incident facility" means a facility where the patient safety sentinel event occurred.

"Medication Error" means medication administration:

(a) of a drug other than as prescribed or indicated;

(b) of a dose other than as prescribed or indicated;

(c) to a patient who was not prescribed the drug;

(d) at a time other than prescribed or indicated;

(e) at a rate other than as prescribed or indicated;

(f) of a improperly prepared drug;

(g) by a means other than as prescribed or indicated; and

(h) administration of a medication to which the patient has a known allergy or drug interaction to the prescribed medication.

"Major permanent loss of function" means sensory, motor, physiologic, or intellectual impairment not present on admission requiring continued treatment or life-style change. When major loss of function cannot be immediately determined, applicability of the policy is not established until either the patient is discharged with continued major loss of function, or two weeks have elapsed with persistent major loss of function, whichever occurs first.

"Patient safety sentinel event" means an event which has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition or is an unexpected occurrence involving death or serious

physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

"Root cause analysis" means a process for identifying the basic or causal factor(s) that underlie variation in performance, resulting in the occurrence or possible occurrence of a patient safety sentinel event.

R380-200-3. Reporting of Patient Safety Sentinel Events.

(1) Each facility shall report to the Department all patient safety sentinel events within seventy-two hours of the facility's determination that a patient safety event may have occurred, but in no event later than four hours prior to convening a formal root cause analysis.

(2) Patient safety sentinel events include:

(a) Surgical Events:

(i) Surgery performed on the wrong body part;

(ii) Surgery performed on the wrong patient;

(iii) Incorrect surgical procedure performed on a patient;

(iv) Retention of a foreign object in a patient after surgery or other procedure, except for:

(A) objects intentionally implanted as a part of a planned intervention;

(B) objects present prior to surgery that were intentionally left in place, and

(C) broken microneedles; and

(v) Intraoperative or immediately post-operative death of a patient who the facility classified prior to surgery as Anesthesia Surgical Assessment Class I. "Intraoperative" means literally during surgery. "Immediately post-operative" means within 24 hours after surgery, or other invasive procedure was completed, or after induction of anesthesia if surgery not completed.

(b) Product or Device Events.

(i) Patient death or disability arising from the use of contaminated drugs, devices, or biologics provided by the facility.

(ii) Patient death or disability associated with the use or function of a device in patient care in which the device is used for an off-label use, except where the off-label use is pursuant to informed consent.

(iii) Patient death or disability associated with intravascular air embolism that occurs while being cared for in the facility, except for intravascular air emboli associated with neurosurgical procedures.

(c) Patient Protection Events.

(i) Infant discharged to the wrong person;

(ii) Patient death or disability arising from a patient elopement or the disappearance of other than competent adults;

(iii) Patient suicide while in the facility or within 72 hours of discharge.

(d) Care management Events.

(i) Patient death or major permanent loss of function arising from a medication error;

(ii) Patient death or major permanent loss of function arising from a hemolytic reaction due to the administration of ABO/HLA incompatible blood or blood products;

(iii) Maternal death or major permanent loss of function in a low-risk pregnancy arising from labor or delivery while being cared for in a facility, except deaths from pulmonary or amniotic fluid embolism, acute fatty liver of pregnancy or cardiomyopathy. "Low Risk Pregnancy" refers to a woman aged 18-39, with no previous diagnosis of essential hypertension, renal disease, collagen-vascular disease, liver disease, cardiovascular disease, placenta previa, multiple gestation, intrauterine growth retardation, smoking, pregnancy-induced hypertension, premature rupture of membranes, or other previously documented condition that poses a high risk of poor pregnancy outcome.

(iv) Unanticipated death of a full-term newborn;

(v) Patient death or major permanent loss of function arising from hypoglycemia, the onset of hypoglycemia which occurs while the patient is being cared for in the facility;

(vi) Kernicterus associated with failure to identify and treat hyperbilirubinemia, bilirubin greater than 30 milligrams per deciliter, in neonates.

(vii) Stage 3 or 4 pressure ulcers acquired after admission to the facility, except for pressure ulcers that progress from stage 2 to stage 3, if the stage 2 ulcer was documented upon admission.

(viii) Patient death or major permanent loss of function due to spinal manipulative therapy; and

(ix) Prolonged fluoroscopy with cumulative dose greater than 1500 rads to a single field;

(x) Radiotherapy to the wrong body region;

(xi) Radiotherapy greater than 25% above the prescribed radiotheraphy dose; and

(xii) Death or major permanent loss of function related to a health care acquired infection.

(e) Environmental Events.

(i) Patient death or major permanent loss of function arising from an electric shock while being cared for at a health care facility, excluding emergency defibrillation in ventricular fibrillation and electroconvulsive therapies;

(ii) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance;

(iii) Patient death or major permanent loss of function arising from a burn incurred from any source while being cared for in a facility;

(iv) Patient death or major permanent loss of function associated with the use of restraints or bedrails while being cared for in a facility; and

(v) Patient death or major permanent loss of function arising from a fall while being cared for in a health care facility, including fractures and intracranial hemorrhage.

(f) Criminal Events.

(i) Any care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed or certified health care provider;

(ii) Abduction of a patient of any age;

(iii) Non-consensual sexual contact on a patient, staff member, or visitor by another patient, staff member or unknown perpetrator while on the premises of the facility; or

(iv) Patient death or major permanent loss of function resulting from a criminal assault or battery that occurs on the premises of the health care facility.

(3) If a facility suspects that a patient safety sentinel event may have occurred to a patient who was transferred from another facility, the receiving facility shall report the suspected patient safety sentinel event to the facility that initiated the transfer.

(4) The report shall be submitted in a Department-approved paper or electronic format and shall include at a minimum:

(a) facility information;

(b) patient information;

(c) event information

(d) type of occurrence;

analysis;

(f) corrective action.

(e)

R380-200-4. Root Cause Analysis.

(1) The incident facility shall establish a root cause analysis process and designate a responsible individual to be the facility lead for each patient safety sentinel event.

(2) The Department representative may participate in the facility's root cause analysis in a consultative role with the facility lead to enhance the credibility and thoroughness of the root cause analysis. The Department shall notify the facility lead within 72 hours of receiving the report of the patient safety sentinel event if it intends to participate in the facility's root cause analysis. The Department representative shall not be present at the facility's internal root cause analysis meetings unless invited by the facility lead.

(3) Participation in the facility's root cause analysis by the Department representative shall not be construed to imply Department endorsement of the facility's final findings or action plan.

(4) The incident facility and the Department shall each make reasonable accommodations when necessary to allow for the Department representative's participation in the root cause analysis.

(5) If, during the review process, the Department representative discovers problems with the facility's processes that limit either the thoroughness or credibility of the findings or recommendations, the representative shall report these to the designated responsible individual orally within 24 hours of discovery and in writing within 72 hours.

(6) The facility shall conduct a root cause analysis which is timely, thorough and credible to determine whether reasonable system changes would likely prevent a patient safety sentinel event in similar circumstances.

(7) The root cause analysis shall:

(a) focus primarily on systems and processes, not individual performance;

(b) progress from specific, direct causes in clinical processes to contributing causes in organizational processes;

(c) seek to determine related and underlying causes for identified causes; and

(d) identify changes which could be made in systems and processes, either through redesign or development of new systems or processes, that would reduce the risk of such events occurring in the future.

(8) The Department shall determine the root cause analysis to be thorough if it:

(a) involves a complete review of the patient safety sentinel event including interviews with all readily identifiable witnesses and participants and a review of all related documentation;

(b) identifies the human and other factors in the chain of events leading to the final patient safety sentinel event, and the process and system limitations related to their occurrence;

(c) searches readily retrievable records to analyze the underlying systems and processes to determine where redesign might reduce risk;

(d) inquires into all areas appropriate to the specific type of event as described in the Joint Commission for the Accreditation of Healthcare Organizations' "Root Cause Analysis Matrix, Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events - October 2005" found at http://www.jointcommission.org/NR/rdonlyres/3CB064AC-2CEB-4CBF-85B8-CFC9E7837323/0/se_root_cause_analysis_matrix.pdf, last viewed on February 22, 2007, which is incorporated by reference.

(e) makes reasonable attempts to identify and analyze trends of similar events which have occurred at the facility in the past;

(f) identifies risk points and their potential contributions to this type of event; and

(g) determines potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or determining, after analysis, that no such improvement opportunities exist.

(9) The Department shall determine the root cause analysis to be credible if it:

(a) is led by someone with training in root cause analysis processes and who was not involved in the patient safety sentinel event;

(b) involves, if necessary, consultation with either internal or external experts in the processes in question who were not involved in the patient safety sentinel event;

(c) includes participation by the leadership of the organization and by the individuals most closely involved in the processes and systems under review;

(d) is internally consistent, i.e., not contradicting itself or leaving obvious questions unanswered;

(e) provides an explanation for all findings of "not applicable" or "no problem;" and

(f) includes consideration of relevant, available literature.

R380-200-5. Reports and Action Plan.

(1) Within 60 calendar days of determination of the patient safety sentinel event, the incident facility shall submit a final report with an action plan that:

(a) identifies changes that can be implemented to reduce risk, or formulates a rationale for not implementing changes; and

(b) where improvement actions are planned, identifies who is responsible for implementation, when the action will be implemented (including any pilot testing), and how the effectiveness of the actions will be evaluated.

(2) The incident facility shall provide a final report to the facility's administration and the Department in a Department-approved paper or electronic format that includes:

(a) type of harm;

(b) contributing factors;

(c) actions taken.

(3) If the Department representative identifies problems with the processes that limit the thoroughness or credibility of the findings and recommendations and that have not been corrected after reporting them to the designated responsible individual, the representative may submit a separate written dissenting report to the administrator of the incident facility, and the Department.

(4) The incident facility may seek review of the dissenting report by filing a request for agency as allowed by the Utah Administrative Procedures Act and Department rule. If a dissenting report is not challenged or is upheld on review:

(a) the facility shall include it in the facility's records of the root cause analysis; and

(b) the Department may forward it, together with the facility's report, to the appropriate state agencies responsible for licensing the facility.

R380-200-6. Confidentiality.

(1) Information that the Department holds under this rule is confidential under the provisions of Title 26, Chapter 3. Because of the public interest needs to foster health care systems improvements, the Department exercises its discretion under Section 26-3-8 and shall not release information collected under this rule to any person pursuant to the provisions of Subsections 26-3-7(1) or (8).

(2) Information produced or collected by a facility is confidential and privileged under the provisions of Title 26, Chapter 25.

R380-200-7. Extensions and Waivers.

(1) The Department may grant an extension of any time requirement of this rule if the facility demonstrates that the delay is due to factors beyond its control or that the delay will not adversely affect the required root cause analysis and the purposes of this rule. A facility requesting a waiver must submit the request to the department representative prior to the deadline for the required action.

(2) The Department may grant a waiver of any other provision of this rule if the facility demonstrates that the waiver will not adversely affect the required root cause analysis and the purposes of this rule.

R380-280-8. Advisory Panel.

The department shall establish a multi-disciplinary advisory panel to assist it in carrying out its responsibilities under this rule. Representatives from facilitites that are required to report under this rule shall be included as members of the advisory panel.

R380-200-9. Penalties.

As required by Section 63-46a-3(5): An entity that violates any provision of this rule may be assessed a civil money penalty not to exceed the sum of $5,000 or be punished for violation of a class B misdemeanor for the first violation and for any subsequent similar violation within two years for violation of a class A misdemeanor as provided in Section 26-23-6.

KEY: hospital, sentinel event, quality improvement, patient safety
Date of Enactment or Last Substantive Amendment: April 26, 2007
Notice of Continuation: October 10, 2006
Authorizing, and Implemented or Interpreted Law: 26-1-30(2)(a); 26-1-30(2)(b); 26-1-30(2)(d); 26-1-30(2)(e); 26-1-30(2)(g); 26-3-8

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	PATIENT SAFETY ORGANIZATION (PSO)		
AL			
AK			**2007 SB 62** - Establishes the Advisory Committee on Public Reporting of Health Care Associated Infections within the Department of Health and Social Services to collect, analyze, and maintain databases of information related to health care associated infections, among previously noted items. **PENDING**
AZ			
AZ-O			**2007 HB 2255 -** Requires each pharmacy to implement or participate in a continuous quality assurance program in order to identify methods for addressing pharmacy medication errors. The Board of Pharmacy shall establish rules to prescribe requirements to document compliance and any other provisions necessary for the administration of the program. **Signed by Governor 4-24-07.**
AR	PSO - Arkansas Patient Safety Initiative		**2007 HB 2387** - Permits an apology to an injured patient by a hospital administrator, physician, or health care worker to be excluded from evidence unless the apology meets the requirements for an excited utterance. **FAILED**

CA	**SB 801**- Requires facilities to implement a formal plan to reduce medication-related errors. (Enacted 3/21/02) **SB 1339**-Requires medication error reporting by pharmacies (Enacted 9/26/00) PSO – California Institute for Health Systems Performance	**Mandatory reporting – Medical Errors –** Specific occurrences are required to be reported by designated health care facilities. The state reviews the reported event and determines if an onsite visit is warranted. (1972) **CA Health and Safety Code Sec. 1339.63** Legislation in 2000 created a medication error reporting system. (2000 SB 1875) – Licensed facilities are required to adopt a formal plan to eliminate or substantially reduce medication errors.	**2007 SB 743** - Requires every licensed general acute care hospital, licensed acute psychiatric hospital, or special hospital, by January 1, 2009, to conduct an assessment of its processes for detecting, reporting, and remediating preventable medical errors, and to prepare a plan for reducing the prevalence of those errors. No later than January 1, 2009, and annually thereafter, the Office of Statewide Health Planning and Development shall publicly report the AHRQ Patient Safety Indicators for each acute care hospital, using discharge data that hospitals report to the office. **PENDING**
CO	Colorado Revised Statutes, sec. 25-1-124	**Mandatory reporting - Medical Errors –**	**2007 EO 6** - Creates the Nurse Workforce and

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
	Code of Colorado Regulations, Ch. 2, Sec.3.2 PSO – Colorado Patient Safety Coalition	**CRS sec. 25-1-124** State -licensed health care facilities are required to report specific occurrences to the Department of Public Health and Environment. (2000)	Patient Care Task Force ("Task Force") to empower consumers of healthcare and enhance nursing satisfaction while improving patient safety and the quality of care provided in Colorado hospitals. The mission is to develop standards and processes for the measurement and disclosure of nurses' contributions to the quality of patient care in license health care facilities and to evaluate the environment of nursing practice in Colorado. **(Issued by Governor 3-29-07)** **2007 HB 1128** - Creates a Health Facilities Advisory Committee on Patient Safety to provide policy guidance to assist the Department of Public Health and Environment in developing standards and innovations at health care facilities in order to ensure patient safety and quality care. **FAILED**

			2007 HB 1133 - States that a health care provider shall not take disciplinary action against a health care worker in retaliation for making a good faith report or disclosure regarding patient safety information. (**Signed by Governor 3-29-07)**
CT	**HB 5715**- Creates a quality of care program (Enacted 6/7/02) – Public Act No. 02-125 **HB 6941**- Requires hospitals to make available to the Commissioner of Public Health its plan for the remediation of medical and surgical errors. (Enacted 7/6/01) **SB 566 –** Establishes that any private or public organization may apply to the Dept. of Public Health to be designated as a patient safety organization. Providers may contract with a patient safety organization to	**Mandatory reporting – Medical Errors** **Public Act No. 02-125** Adverse events are classified into four categories, Classes A-D. Hospitals and outpatient surgical facilities are required to report Classes A-C adverse events to the Department of Public Health within 24 hours of the occurrence and Class D events on a quarterly basis. Reports must include corrective action plans.	**2007 SB 1191** - Requires hospitals to disclose to the public information about their hospital staffing levels. **FAILED**

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
	conduct activities intended to improve patient safety. A patient safety organization must ensure confidentiality of the patient safety work product, which is defined in the bill. The bill also requires hospitals and outpatient surgical facilities to report adverse events to the Dept. of Public Health within 7 days. (Enacted 6/1/04)		
DE			
DC			

FL	Fla. Stat. Ch. 395.0197 (2003) – Requires licensed facilities to have an internal risk management program that includes investigation and analysis of specific types of adverse incidents. PSO – Patient Safety Steering Committee		**2007 HB 457 (HB 487, SB 884, SB 1184) -** Enacts the Safe Staffing for Quality Care Act that states that the basic principles of staffing in health care facilities should be focused on patient health care needs and based on consideration of patient acuity levels and services that need to be provided to ensure optimal outcomes. Establishes staffing standards for workers in a health facility. **FAILED**
GA	Georgia Rules 290-9-7-.07 PSO - Partnership for Health & Accountability	**Voluntary reporting system**	**2007 HB 61** - Requires individual hospitals and ambulatory centers to collect data on hospital acquired infection rates for certain categories of procedures, and for hospitals and ambulatory centers to submit quarterly reports to the Department of Human Resources. **PENDING 2007 SB 150** - Creates a website for the purpose of providing consumers information on the cost and quality of health care in GA. Requires health care providers to provide patients with a copy of their medical records at least once per year at no cost, either electronically or print. **PENDING**
GU			
HI	**HCR 190/SCR 75**-Requests the Patient Safety Task force to submit a report of its efforts to reduce medical errors. (Passed both houses in April 2002)		**2007 HB 1253** -Allows individuals, corporations, and government entities to offer apologies or other expressions of sympathy without fear of such gestures being used against

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION

	SB 2577 – Provides for confidentiality for the proceedings and records of health care review organizations and case review forums. (Enacted 5/5/04)		them to establish civil liability. **(Signed by Governor 5-23-07) 2007 SB 670 (SB 813)** - States that in any civil action that is brought against a health care provider or in any arbitration procedure that relates to the civil action, any statement, writing or benevolent gesture from the health care provider is inadmissible as evidence of liability. A statement of fault is admissible. **PENDING**
ID			
IL	**HB 4580** - Appropriates funds to maintain and improve patient safety and quality of care. (Enacted 6/28/02) **HB 2345** - Created the Electronic Health Records Taskforce to create a plan for the development and utilization of electronic health records in the State in order to improve the quality of patient care, increase the efficiency of medical practice, improve safety, and reduce medical errors. (Enacted 8/22/05)		**2007 HB 392** - Requires every hospital to implement a staffing plan that provides adequate, appropriate, and quality delivery of health care services and protects patient safety. **PENDING 2007 SB 361** - Enacts the Patient Acuity Nursing Staffing Act to require that every hospital implement a written hospital-wide staffing plan that includes a matrix for staffing decision-making that provides for minimum direct care professional registered nurse-to-patient staffing needs for each unit of care. **PENDING 2007 SB 605** - Requires every hospital to implement a staffing plan that provides adequate, appropriate, and quality delivery of health care services and protects patient safety. Allows a nurse to reject an assignment that the nurse is not prepared by education, training or experience to fulfill the assignment without compromising the safety of any patient. **PENDING 2007 SB 867** - Amends The Hospital Licensing Act to add a section regarding nurse staffing by

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
			patient acuity. **PENDING**

IN			**2007 EO 5** - Strengthens transparency and accountability through value driven health care. This order encourages health insurance plans, third party administrators, providers and others with state contracts, to encourage high quality and patient safety by taking consistent actions to achieve the following goals: (1) support health information technology; (2) provide pricing information; and (3) promote quality and efficiency of care. **(Issued by Governor 3-7-07) 2007 SB 207** - Requires a health care facility to file, with an agency selected by the Department of Health, patient safety incident reports concerning certain acts that have caused or could have caused harm to a patient. **(Signed by Governor 5-2-07) 2007 SB 513** - Requires the State Department of Health to establish a list of health entity acquired infections for which data must be collected by health entities. The list must include surgical site infections, ventilator associated pneumonia, central line related bloodstream infections, urinary tract infections, and other infections as determined by the department. **FAILED 2007 SB 531** - Establishes the Infection Control Advisory Commission to study and devise methods for health care facilities to track and report the occurrence of health care associated infections and to provide advice on other topics requested by the State Department of Health. **FAILED**
IA	PSO – Patient Safety Advisory Committee		

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
	Peer Review Reporting – Iowa Code 147.135(3)		
KS	KSA 65-4923 (2002) Kansas Admin. Code, 25-52-1	**Mandatory reporting – Medical Errors KSA 65-4923 – Chapter 65, Article 49** Medical providers and employees of health care facilities are required to report an act by a health care provider that (1) is or may be below the applicable standard of care and has reasonable probability of causing injury to a patient or (2) may be grounds for disciplinary action by the appropriate licensing board.	**2007 HB 2156** - States that a court may not admit into evidence a communication of sympathy that relates to a loss, an injury, pain, suffering, a death, or damage to property. However, an admission of fault, including a statement of fault that is part of a communication of sympathy, may be admitted. **PENDING 2007 HB 2271** - Requires each health care provider to make available for public disclosure the health care provider's quality and performance indicators for certain and common health or medical care services. **PENDING**
KY	Reporting Actions Taken Against Licensed Physicians - KRS 311.606	**Mandatory Reporting KRS 311.606** Contains requirements for professional medical associations and hospitals to report actions taken against a licensed physician to the medical board. Also requires clerks of the Circuit and District Courts to report all criminal convictions of licensees to the medical board.	
LA			

ME	**SB 419**-Establishes the Maine Health Care Quality Improvement Center and creates a mandatory reporting system for medical errors, events and incidents. It requires health care facilities to report medical errors, events and incidents within one business day of discovering the occurrence. (Enacted 4/11/02) – Me. Rev. Stat. Ann. Title 22, 8753	**Mandatory reporting – Medical Errors MRSA - Title 22, Chapter 1684** Legislation created the Maine Health Care Quality Improvement Center under the Department of Health and Welfare and requires Health care facilities to report medical errors, Events, and incidents to the Department of Health by the next business day after the occurrence is discovered. The Center will use sentinel event reports to conduct research and analyze data, and create a clearinghouse to educate the public and health care providers on how to reduce medical errors and improve patient	**2007 SB 156** - Requires the Board of Medical Licensure and Discipline to submit by March 1st of each year to the legislature and to all surgeons and physicians a report consisting of an analysis of all medical injury claims filed with the board for the preceding year. The report may not include names or other identifying information of any parties in the claims, but there must be a determination of causation in the board's findings of negligence. The report must also include suggested actions to minimize reoccurrence of negligence. **PENDING**

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		safety. (2002 – SB 419)	**2007 SB 221** - States that an expression of regret or apology or an explanation of how a medical error occurred made by or on behalf of a health care provider that is provided within fourteen days of when the provider knew or should have known of the consequences of the error does not constitute a legal admission of liability and is inadmissible in a civil or administrative proceeding. **PENDING**

MD	**HB 1274**-Requires the Maryland Health Care Commission to study the feasibility of developing a system for reducing the incidences of preventable adverse medical events including a system of reporting incidents. (Enacted 2001) **MD Code, Health Occupations, Section 14-413 PSO – Maryland Patient Safety Coalition**		**2007 HB 147** - States that a provider who makes an expression of regret or apology to a victim of alleged health care malpractice, any member of the victim's family, or any individual who claims damages by or through that victim, outside the presence of any other individual, such statement is inadmissible as evidence of an admission of liability or as evidence of an admission against interest. **FAILED 2007 HB 979** - Requires the Health Services Cost Review Commission to provide funding through hospital rates of $10,000,000 each year to establish a regional health data exchange that provides connections among hospitals and health care practitioners. The regional heath data exchanges funded through this program are set to carry forward the momentum created by the Task Force to Study Electronic Health Records. (**Signed by Governor 4-24-07)**
MA	**Medical Malpractice Reform Act of 1986 -** Mandated the Board of Registration in Medicine's Patient Care Assessment (PCA) function. **M.G.L. Chapter 112, Section 5** – Provides that the Board of Registration in Medicine establish a risk management unit to provide technical assistance and	**Board of Registration in Medicine Regulations 243 CMR 3.00 – 3.16 –** Specify in detail the requirements of the patient safety and adverse event reporting systems. The Patient Care Assessment function is responsible for the oversight of institutional systems of quality assurance, risk management, peer review,	**2007 HB 1370 (SB 987)** -States that in any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence,

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	quality assurance programs designed to reduce or stabilize the frequency, amount, and costs of claims against physicians and hospitals licensed or registered in the commonwealth. Requires board to promulgate regulations requiring physician participation in the risk management programs as a condition of licensure. **M.G.L. Chapter 111, Section 203 (d)** - Requires every licensed hospital, as a condition of licensure, and every public hospital to participate in risk management programs established by the Board of Registration in Medicine. **M.G.L. Chapter 111, Sections 204 and 205; 243 CMR 3.04 –** Provides that PCA information is confidential and not subject to subpoena, discovery or introduction into evidence. **HB 4800**-Established the Betsy Lehman Center for Patient Safety and Medical Error Reduction. The center will coordinate the efforts of state agencies and those individuals or institutions licenses to provide health care to meet their responsibilities for patient safety and medical error reduction; assist health care providers, including institutions, to work as part of a total system of patient safety; develop and administer a patient safety and medical error reduction education and research program; and develop appropriate mechanisms for consumers to include in a statewide program for improving patient safety. The center will coordinate state participation in any appropriate state or federal reports or data collection efforts relative to patient safety and medical error reduction. The center will also analyze available data, research and reports for information that would improve education and training programs that promote patient safety. (Enacted 2001) **M.G.L. Chapter 6, Section 16E.**	utilization review, and credentialing.	compassion, mistake, error, or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding and shall not constitute an admission of liability or an admission against interest. **PENDING 2007 HB 2072 (SB 1271)** - A hospital shall report each never event occurrence listed in regulations to the Betsy Lehman Center for Patient Safety and Medical Error Reduction, the Department of Public Health, the Board of Registration in Medicine's Patient Care Assessment division, and the Health Care Quality and Cost Council, as soon as is reasonably and practically possible, but no later than 15 working days after discovery of the never event. Any licensed hospital in the Commonwealth, which does not comply with this section and the rules and regulation set forth by the department may have its license revoked or suspended by said department, be fined up to $1,000 per day per violation, or both. **PENDING 2007 HB 2226 (SB 1277)** - Requires a health care provider who reasonably believes that an adverse event has occurred shall report the adverse event to the management of the facility where the event occurred unless the health care provider knows that a report has already been made. **PENDING 2007 SB 419** - Requires the Betsy Lehman

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	PSO – Massachusetts Coalition for the Prevention of Medical Errors		center for patient safety and medical error reduction, to convene a task force, which shall develop recommendations on methods for reducing medication and prescription errors including recommendations on: (1) increasing prescription legibility; (2) minimizing confusion in prescription drug labeling and packaging; (3) developing medication error reporting plans; (4) researching the effect of proven medication safety practices, including the use of automated drug-ordering systems; (5) reducing confusion created by similar-sounding drug names; (6) increasing patient education on the medications they are prescribed; (7) developing education programs for any person who writes prescriptions and reviewing the education programs for new practitioners and the continuing education requirements of established practitioners, including, but not limited to, programs offered to practitioners to educate them on the cost effective therapeutic alternatives to prescriptions; and (8) studying the issue of whether any dispensed prescription medication, other than those in unit dose or unit of use packaging, shall be labeled with its physical description, including, but not limited to, color, shape and any identification code that may appear on tablets and capsules. **PENDING 2007 SB 1246** - Directs a hospital within 24 hours of instituting any disciplinary action against any physician providing services within the hospital or becoming aware of any disciplinary action taken by the hospital or by any subsidiary of the hospital or any physician group contracting to provide services within the hospital against any physician providing services within the hospital, shall notify all

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			patients being cared for by that physician within that hospital. **PENDING 2007 SB 1264** - Calls for the establishment within the Executive Office of Health and Human Services, a special commission to investigate and make recommendations on the establishment of performance standards for physicians that will improve patient outcomes and the means of measuring professional performance. **PENDING 2007 SB 1284** - Encourages health professionals to apologize for medical mistakes and states that any statement of apology shall be exempt from public disclosure, subpoena or discovery. **PENDING**
MI	**HB 5260**- Requires the establishment of an electronic monitoring system to monitor the dispensing of Schedules II-V controlled substances. (Enacted 1/03/02) **PSO – Michigan Health and Safety Coalition**		**2007 HB 4708** - States that a writing, statement or action expressing sympathy, compassion, commiseration or a general sense of benevolence relating to the pain, suffering or death of an individual made to the individual or to the individuals' family is inadmissible in an action for medical malpractice. **PENDING**

MN	Minnesota Statutes, Sec. 144.706 et seq. **SB 4a-** Directs the Commissioner of Health to conduct a patient care and safety study. (Enacted 6/29/01) **MN SB 1019 --** Establishes a medical error reporting system for health care facilities. Facilities must report to the Commissioner of Health within 15 days of an adverse incident. The bill lays out what events are required to be reported. (Enacted 5-27-03) **MN SB 2365** - Modifies the reporting system under the Minnesota Adverse Health Care Events Reporting Act of	**Mandatory Reporting - Medical Errors** Reporting system requires hospitals to report a list of 27 significant events or incidents to a system mandated by the Commissioner of Health and operated by the MN Hospital Association. Commissioner must analyze adverse event reports, corrective action plans, and findings of the root cause analysis and communicate recommendations to health care facilities and publish an annual report. (2003 – SB 1019)	**2007 HB 712** - Requires by January 1, 2010, that every licensed health care facility to implement a safe patient handling program to eliminate manual lifting of patients by nurses and direct patient care workers through the use of mechanical assistive devices, except during emergency situations. **PENDING 2007 HB 2343** - States that in any civil action brought by an alleged victim of an unanticipated outcome of medical care, or in any arbitration proceeding related to that civil action, statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration,

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	2003. Expands the exclusion of maltreatment of vulnerable adults from adverse health events to maltreatment of minors and to neglect under both the minors or vulnerable adults maltreatment reporting acts; modifies certain investigation requirements and classifying certain data; requires certain additional reports from the health related licensing boards; exempts members and employees of the boards of medical practice, chiropractic examiners, pharmacy and podiatric medicine from liability for making certain reports or for maintaining certain records, requires the boards to maintain records of events qualifying as adverse health care events and to forward the reports to the commissioner of health; modifies the notice requirement of the commissioner relating to implementation of the +reporting system . (Enacted 5-11-04) **PSO – Minnesota Alliance for Patient Safety**		condolence, compassion, or a general sense of benevolence, made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim and which relate to the discomfort, pain, suffering, injury, or death of the alleged victim as a result of the unanticipated outcome of medical care is inadmissible as evidence of an admission of liability or as evidence of an admission against interest or as an excited utterance. **PENDING**
MS			

MO	**RSMO – Section 383.133 MO EO 6 –** By means of an Executive Order the Governor created the Missouri Commission on Patient Safety to study and recommend legislative, administrative, clinical, behavioral, and technological measures to improve medical outcomes, prevent errors, upgrade healthcare delivery, and improve education of medical providers and patients with the goal of reducing the incidence of preventable medical errors and reducing the number of medical malpractice claims. The Commission is assigned to the Missouri Dept. of Insurance and is directed to report recommendations to the Governor by July 1, 2004. **Issued 2-3-04.**		**2007 HB 588** - States the Department of Health and Senior Services shall have the power to promulgate regulations defining terms and prescribing the process for establishing a standardized acuity-based patient classification system, regulations providing for an accessible and confidential system to report any failure to comply with the requirements, to develop a standardized acuity-based patient classification system to be utilized by all hospitals and ambulatory surgical centers to increase the number of direct-care registered nurses to meet patient needs by the nurse-to-patient ratios, and to promulgate rules that as a condition of licensing, each hospital or ambulatory surgical center shall submit annually to the department a prospective staffing plan together with a written

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			certification that the staffing plan is sufficient to provide adequate and appropriate delivery of health care services to patients for the ensuing year. **PENDING 2007 HB 799** - Requires by January 1, 2008, that every licensed hospital compile and post daily in the patient care area of each unit of the hospital, and provide upon request to a member of the public, information detailing nursing staff levels for each unit and for the end of the prevailing shift. **PENDING 2007 HB 1061 (SB 578)** - Requires hospitals to report certain incidents involving patient safety to a patient safety organization for review. **PENDING**

MT	HB 254 - Makes writing illegible prescriptions a civil offense. (Enacted 4/28/05)		
NE	NRS 71-168.02 requires facilities licensed under the Health Facility Licensure Act to report when the facility has made payment due to adverse judgment, settlement or award of a professional liability claim against it or a licensee and when the facility takes action adversely affecting the privileges of a licensee due to alleged incompetence, professional negligence, unprofessional conduct or physical or chemical impairment.	**Mandatory reporting** Title 172, Chapter 5; Mandatory Reporting by Health Care Professionals, Facilities, Peer and Professional Organizations, and Insurers Establishes mandatory requirements for self-reports by a health care professional; reporting within a health care profession; reporting between health care professions; reporting by peer review organizations and professional associations; and reporting by insurers	**2007 LB 373** - States that in any civil action brought by an alleged victim of an unanticipated outcome of medical care, any and all statements, affirmations, gestures or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence, which are made by a health care provider to the alleged victim or victim's family, shall be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. A statement of fault which is otherwise admissible and is part of or in addition to any such commiseration shall be admissible. **(Signed by Governor 5-21-07)**
NV	Nev. Rev. Stat. Ann. 439.835 (2003) **ACR 7-**Studying the development of a system for reporting medical errors. (Adopted 5/9/01)	**Mandatory Reporting – Medical Errors** Legislation requires employees of a medical facility to notify a designated patient safety officer of any sentinel events that occur in the facility within 24 hours. Such events must then	

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		be reported to the Repository for Health Car Quality within the Health Division. The repository will function as a clearinghouse of information relating to aggregated trends of sentinel events. (AB 1 – 2002)	

NH	**HB 396**- Encourages physician practices to improve quality of care through quality assurance programs. (Enacted 6/26/01)	**Mandatory reporting** The Board of Medicine has formulated written guidelines for what actions must be reported to the Board under **RSA 151-6-b.** They include reduction, restriction, suspension, revocation, termination or denial of clinical privileges or medical staff appointment or employment unless the change was voluntary because of the licensee's desire to limit practice, but not as a result of a past clinical quality of care issue. Behavior incompatible with the role of a Physician including illegal, immoral or unethical behavior shall also be reported.	
NJ	New Jersey Regulations NJAC 8:43G-5.6	**Mandatory reporting**	
NM		**Voluntary reporting system**	
NY	New York PHL, Sec. 2805(1) New York Code of Rules and Regulations Title 10, Section 405 **SB 8127** Patient Health Information and Quality Improvement Act of 2000. The bill established a patient safety center within the Department of Health in order to maximize patient safety, reduce medical errors and improve the quality of health care by improving public access to health care information. The Center will collect information on medical error reduction and establish goals and best practices. (Enacted 10/6/00)	**Mandatory reporting** Hospitals are required to report any unintended adverse and undesirable development in an individual patient's condition. A list of 47 occurrences are included in the list of reportable events.	**2007 AB 3790** - Requires a health care provider to disclose to his or her patient or patient's representative any error in diagnosis, treatment, or other service by the health care provider that the provider knows has caused substantial harm or significant risk of substantial harm to the patient. A health care provider shall not be liable for failure to disclose an error, harm or risk of harm if the provider reasonably believes that another health care provider has already made such disclosure. **PENDING 2007 AB 4963 (SB 2810)** - Requires the Commissioner of Health to develop and implement a system for color-coding standardization of patient wristbands of medical safety conditions for use in all health care facilities. **PENDING**

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			2007 AB 5196 - Requires certain health facilities to disclose to the public information regarding nurse staffing and patient outcomes. **PENDING** **2007 AB 5525** - Requires the Commissioner of Health to make regulations to establish and ensure safe staffing standards for all health care facilities that apply only to registered professional nurses, licensed practical nurses and assistive nursing personnel. **PENDING** **2007 AB 7899** - Establishes the Consumer Assistance Unit on Professional Medical Conduct to act as a liaison for consumers to assist them in dealing with the Office of Professional Medical Conduct. Requires the Office of Professional Medical Conduct to conduct a professional misconduct investigation of a provider upon receipt of a certain number of reports of incidents within specified time limits. Further, medical experts in cases referred to an investigation committee involving issues of clinical practice must be qualified by sufficient training or experience to render an opinion on the matter at issue. Further, a health care provider is required to disclose to a patient any error in diagnosis, treatment or other service by the provider that the provider knows has caused substantial harm or significant risk of substantial harm to the patient. **PENDING** **2007 AB 8106 (SB 5648)** - Encourages cooperative, collaborative and integrative arrangements among general hospitals, among physicians, and among general hospitals and physicians involving clinical integration in order

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			to seek improvements and efficiencies in health care and reduce medical errors. **PENDING** **2007 AB 8107 (SB 2482)** - Requires certain health facilities to ensure they are staffed in a manner that provides sufficient, appropriately qualified nursing staff of each classification in each department or unit within the facility in order to meet the individualized care needs of patients. **PENDING**
NC	**NCGS 90-14.13** – Requires hospitals, HMOs, and other health care institutions to report to the Board any revocation, suspension, or limitation of a physician's privileges. Insurance companies are required to report any award for damages or any settlement of any malpractice complaint affecting a physician within 30 days of the award or settlement.	**Mandatory reporting of certain actions or events**	**2007 HB 136 (SB 64)** - States that the Legislative Research Commission may study the incidence and causes of medical errors occurring in hospitals, pharmacies, and other health care settings and make an interim report to the 2007 general assembly, regular session 2008, and make its final report to the 2009 general assembly. **PENDING 2007 HB 1738** - Establishes the Advisory Commission on Hospital Infection Control and Disclosure to prepare State agencies, hospitals, and the public for reporting and public disclosure of hospital-acquired infection incidence rates for specific clinical procedures relating to class I surgical site infections, ventilator-associated pneumonia, and central line-related bloodstream infections. **PENDING**
ND			**2007 HB 1333** - Provides that expressions of empathy by health care providers are inadmissible in a civil action, arbitration proceeding, or administrative hearing regarding the health care provider. **(Signed by Governor 3-2-07)**

NMI			
OH	OH Dept. of Health Reporting Requirements, Rev. Code Sec. 3702.11 OH Administrative Code Chapter 3701-84	**Mandatory reporting**	

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	PSO – Ohio Patient Safety Institute		
OK			
OR	**HB 2349 –** Creates the Oregon Patient Safety Commission. The Commission is required to establish a voluntary adverse event reporting system that will gather data and analyze that data to identify quality improvement techniques and best practices that will reduce systems errors that contribute to patient harm and to disseminate that information. The Commission must create incentives to encourage participation in the reporting program. (Enacted 8-14-03). - **ORS 677.415**	**Voluntary reporting – Medical Errors** Voluntary reporting system created by the Oregon Patient Safety Commission to receive voluntarily reports of serious adverse events, root cause analyses of such events, and action plans established to prevent similar events. (2003- HB 2349)	

PA	Pa. Stat. Ann. Title 40, 1303.308 (2003) Pa. Stat. Ann. Title 40, 1303.313 **HB 1802**-Creates the Patient Safety Authority. The Authority will be responsible for contracting with an organization to collect, analyze and evaluate data regarding reports of serious events and incidents, including identifying patterns. (Enacted 3/20/02) **PSO – Pennsylvania Patient Safety Collaborative**	**Mandatory reporting – Medical Errors** A Patient Safety Authority was created to receive mandated reports, from hospitals, birthing centers and ambulatory surgical facilities, of serious events (occurrences that are undesirable and result in injury that requires additional medical care) and incidents (occurrences that are undesirable that could have resulted in injury). Anonymous reports are permitted. Authority must collect, analyze, and evaluate reported data. (HB 1802 – 2002)	**2007 HB 171** - Requires the Department of Health to adopt regulations prescribing the method by which it will approve a health facility's acuity system. Each health care facility shall ensure that it is staffed in a manner that provides sufficient, appropriately qualified direct-care nurses in each department or unit within the facility. Each facility is required to have a staffing plan and maintain daily statistics, by nursing department and unit, of mortality, morbidity, infection, accident, injury and medical errors. **PENDING 2007 HB 303** - Provides medical malpractice premium discounts to health care providers who institute total quality management health care systems within their practices. The Department of Health must determine that the provider's system will successfully reduce medical errors. **PENDING 2007 HB 311** - States that in any medical professional liability action, any benevolent gesture or admission of fault made by a health care provider to a patient, or the patient's relative or representative, regarding the patient's

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			discomfort, pain, suffering, injury or death resulting from a medical treatment or procedure shall be inadmissible as evidence of liability if the gesture or admission was made prior to the commencement of the medical professional liability action. **PENDING 2007 HB 353** - Enacts the Adverse Health Care Events Reporting Act to require health facilities to report adverse health care events to the Department of Health as soon as is reasonably and practically possible but no later than fifteen working days after discovery of the event. **PENDING 2007 HB 742 (SB 217)** - Enhances patient safety by establishing meaningful whistleblower protection and a reporting system for medical errors which is responsive to legitimate concerns. **PENDING 2007 HB 1010** - Amends the Medical Care Availability and Reduction of Error (Mcare) Act by adding a section on patients' visitation rights. It authorizes the right of a patient to designate individuals as visitors so that these designees may accompany the patient while the patient is receiving treatment from a health care provider. **PENDING 2007 HB 1043** - Establishes minimum staffing standards for unlicensed and licensed nursing personnel at long-term care nursing facilities and requires such information be posted for the public. **PENDING 2007 HR 49** - Urges the Department of Health to study, review and make recommendations

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			relating to the impositions of statewide standards for uniformity in the use by health care providers of color-coded patient wristbands and submit their findings to the House of Representatives no later than July 31, 2007. **PENDING 2007 SB 12** - States the State Board of Medicine shall not approve for accreditation any graduate medical education program that does not require a minimum of six hours of patient safety training. Also states Board of Medicine may utilize a program similar to the impaired professional program through which a licensee may be referred for a clinical skills assessment to improve clinical skills or address any clinical skills deficiencies. **PENDING**
PR			
RI	Rhode Island Statutes, Section 23-17-40 **SB 2675**- Requires hospitals to report adverse events as a condition of licensure. (Enacted 6/28/02)	**Mandatory reporting – Medical Errors** Hospitals are required to report a list of events that are not expected or probable that result in extended hospital stay or death of the patient. (2002 SB 2675)	**2007 SB 650** - Establishes the Patient Safety and Medical Error Reduction Act to require each hospital to participate in a comprehensive program to improve patient safety and reduce medical errors in that hospital. **PENDING** **2007 SB 655 -** States that expressions of sympathy by a health care provider to a patient or to the patient's family regarding the outcomes of the patient's medical care and treatment are inadmissible as evidence or an admission of liability in a civil action against the provider. **PENDING**
SC	SC Code of Regulations, No. 61-16	**Mandatory reporting**	

SD	Administrative Rules of SD 44:04:01:07 **SB 55-** Medication Error Reporting (Enacted 3/3/00)	**Mandatory reporting** All licensed health care facilities are required to report specific occurrences to the State Health Department. Medication error reporting system (2000 SB 55)	

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
TN	Tennessee Rules Chapter 1200-8-1. SB2316 **SB 2316-** Requires health facilities to report unusual or adverse events to the Department of Health within 7 business days (Enacted 3/19/02) **PSO – Tennessee Improving Patient Safety**	**Mandatory reporting – Medical Errors** Legislation requires health facilities to report a list of unusual events to the Department of Health within seven business days. Facilities are also required to submit a corrective action plan. (2002 SB 2316)	**2007 HB 1334 (SB 1347) -** Establishes the Sorry Works! Pilot Program to require participating hospitals and physicians to promptly disclose and identify, acknowledge and apologize for mistakes in patient care and promptly offer fair settlements. **PENDING**

TX	TX Health and Safety Code Sec. 241.201-241.210 (2003) The Texas Board adopted rules in **April 2004** that require hospitals and ambulatory surgical centers to establish patient safety programs. The program must define medical errors, adverse events, and reportable events. Specific events must be reported, including: medication errors; suicide of a patient; abduction of a patient; sexual assault of a patient; blood transfusion reaction in a patient; surgical procedure on the wrong patient or on the patient's wrong body part; patient death or serious disability; and a foreign object left in a patient during a procedure. **PSO – Texas Patient Safety Alliance**	**Mandatory hospital reporting**	**2007 HB 678** - Requires health-care facilities to report the health care associated infection rate for that health care facility to the Department of State Health Services. **FAILED 2007 HB 1398** - Requires the Commissioner of State Health Services to establish the Advisory Panel on Health Care-Associated Infections to guide the implementation, development, maintenance, and evaluation of the reporting system. The purpose of the reporting system is to provide for the reporting of health care-associated infections by health care facilities to the department, the public reporting of information regarding the health care-associated infections by the department, and the education and training of health care facility staff by the department regarding this chapter. **FAILED TX HB 1707 -** States that each hospital shall maintain an organized nursing service that is adequately organized, equipped, and staffed to meet the needs of the hospital's patients. **FAILED**
UT	UT Division of Administrative Rules, R380-200 **PSO – Utah Patient Safety Consortium**	**Mandatory Reporting**	
VT			
VA	**SB 316**Related to civil immunity, privileged communications, and confidentiality of patient safety data. (Enacted 4/6/02)		**2007 HB 2583** - Requires a physician to file a written report with the Department of Health regarding each patient who comes under the

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION

	HB 2763- Requires other entities (in addition to hospitals) to report certain health care data. (Enacted 3/19/01) **PSO – Virginians Improving Patient Care and Safety (VIPCS)**		physician's care and requires medical treatment or suffers death that the attending physician has a reasonable basis to believe is the result of an elective outpatient surgical procedure. **FAILED**
VI			
WA	Washington Administrative Code, Section 246-320-145 **HB 2798**- requires the Department of Health, consulting with the Board of Pharmacy and professional licensing boards, to develop recommendations on ways to reduce medication errors. Among other provisions the law requires a medication error reporting system and improve prescription drug labeling to reduce mistakes. (Enacted 3/17/00)	**Mandatory hospital reporting** Legislation in 2000 required the Department of Health to develop recommendations on ways to Reduce medication errors. Creates a medical error reporting system.	**2007 HB 1809 (SB 5696)** - Creates the Advisory Committee on Nurse Staffing to recommend patient assignment limits, recommend quality indicators, and to make other recommendations regarding the development and implementation of hospital staffing plans. The goals of this program are to protect patients and to support greater retention of registered nurses, to promote evidence-based nurse staffing, and to increase transparency of health care data and decision-making by ensuring that sufficient nurse staffing meets patient care needs. **FAILED** **2007 SB 6057** - Requires each hospital to establish an advisory committee on staffing to recommend patient assignment limits to be adopted by the Department of Social and Health Services to , make classifications to the state hospital; and the safety committee regarding safe equipment and personal alarm system policies, and make other recommendations regarding the development and implementation of hospital staffing plans that the staffing committee deems necessary. **FAILED**
WV	**HB 2506**- Whistleblower protection (4/30/01)		
WI	**PSO – Wisconsin Patient Safety Institute**		**2007 AB 53** - Establishes that a statement or gesture of a health care provider, or a health care provider's employee or agent, that expresses apology, benevolence, compassion,

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STATE	EXISTING STATUTE OR LEGISLATION & PATIENT SAFETY ORGANIZATION (PSO)	REPORTING REQUIREMENTS/	PENDING LEGISLATION
			condolence, or sympathy to a patient or to his or her relative or representative is not admissible into evidence or subject to discovery in any civil action or administrative hearing regarding the health care provider as evidence of liability or as an admission against interest. **PENDING**
WY		**Voluntary reporting system**	
Federal	SB 544 - The "Patient Safety and Quality Improvement Act of 2005" establishes a voluntary and confidential reporting system in support of initiatives to reduce preventable medical errors. (Enacted 7/29/05)		

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State Issue	Status	LegType	Bill Number	Bill Summary
Alaska	Complementary and Alternative	Pending	SB 107	Creates the Naturopathic Advisory Committee within the Department of Medicine Health. The Committee will: review allegations of misconduct involving naturopaths; advise the department on the approval of naturopathic medical programs; and advice the department on the adoption of regulations.
Alaska	Miscellaneous	Substituted	SB 8	States that a mental health patient has the right to have care provided by a staff member who is the gender that the patient requests.
Alaska	Medical Errors/Patient Safety	Pending	SB 62	Establishes the Advisory Committee on Public Reporting of Health Care Associated Infections within the Department of Health and Social Services to collect, analyze, and maintain databases of information related to health care associated infections, among previously noted items.
Alaska	Medical Board Organization & Authority	Pending	HB 114	Extends the sunset date of the Medical Board from June 30, 2007, to June 30, 2013.
Alaska	Physician Practice	Pending	HB 300	Requires physicians to attending or making a postnatal examination of a mother and infant to document the infant's prenatal exposure to alcohol in the infant's medical file, if the mother provides her consent to the inclusion of the information in the infant's medical file.
Alaska	Physician Practice	Pending	SB 252	Requires physicians to attending or making a postnatal examination of a mother and infant to document the infant's prenatal exposure to alcohol in the infant's medical file, if the mother provides her consent to the inclusion of the information in the infant's medical file.
Alaska	Complementary and Alternative	Substituted	HB 363	Establishes the Naturopathic Board and authorizes a naturopath to Medicine prescribe and administer prescription drugs and medical devices approved on a formulary.
California	Physician Practice	Pending	AB 2968	Enacts the Donda West Law, which prohibits the performance of an elective cosmetic surgery on a patient unless, prior to surgery, the patient has completed

a physical examination by, and has received written clearance for the for the procedure from, a licensed physician and surgeon.

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State	Issue	Status	LegType	Bill Number	Bill Summary
California	Extending Health Care Services to Underserved Patient Populations	Failed	SB	236	States the intent of the Legislature to enact legislation to improve access and affordability of health care to Californians. Addresses issues such as allowing hospitals to offer preventive health services only coverage where the actual care is delivered through a hospital's primary care or community-based clinics; allow nurse practitioners to establish and run primary care clinics; provide a partial tax credit directly to providers for the cost of providing care to the uninsured; realign and extend health care coverage for the uninsurable population; conform California's laws to federal law with respect to providing tax deductions for businesses and individuals who use health savings accounts; and provide a tax credit for hospitals and physicians and surgeons who purchase cost-saving and quality-improving technologies such as electronic medical records and telemedicine and establish a low-interest loan program to assist nonprofit hospitals and medical groups make health care technology purchases.
California	Extending Health Care Services to Underserved Patient Populations	Pending	AB	6	AB 6a Creates the California Physician Assistant Scholarship and Loan Repayment Program to provide scholarships to physician assistant students and to repay qualifying educational loans of physician assistants who agree to practice in medically underserved areas of the state where unmet priority needs exist for primary care family physicians.
California	Scope of Practice	Failed	SB	24	SB 24a Provides for activities that a nurse practitioner is authorized to engage in and allows a nurse practitioner to prescribe drugs and devices if he or she has been certified by the board to have satisfactorily completed at least 6 months of supervised experience in the prescribing of drugs and devices. Drugs and devices prescribed may include Schedule II through Schedule V controlled substances. The bill also requires all nurse practitioners authorized to prescribe to register with the United States Drug Enforcement Administration, and the bill deletes the prohibition against a

					physician and surgeon supervising more than 4 nurse practitioners at one time.
California	Pain Management/Prescription Monitoring	Amended	AB	2747	Requires an attending physician who makes a diagnosis that a patient has a terminal illness or makes a prognosis that a patient has less than one year to live to provide the patient with the opportunity to receive comprehensive information and counseling regarding legal end-of-life options and provide for the referral or transfer of a patient if the patient's physician does not wish to comply with the patient's choice of end-of-life options.
California	Physician Practice	Amended	AB	2398	Requires a physician or surgeon who delegates the performance or administration of any cosmetic medical procedure or treatment to provide immediate supervision of that procedure or treatment and to have performed an initial, good faith, and appropriate prior examination of the patient for whom treatment has been delegated. Provides that a violation of this provision may subject the person or entity that has committed the violation to either a fine of up to $25,000 per occurrence pursuant to a citation issued by the Medical Board or a civil penalty of $25,000 per occurrence.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
California	Physician Practice	Pending	AB	2841	Enacts the Reusable Adipose Cannula Full Disclosure Act, which requires a physician and surgeon to provide specified written disclosures to a patient prior to that patient undergoing any adipose medical procedure for which a reusable adipose cannula is to be used.
California	Scope of Practice	Pending	SB	1427	Authorizes a prescribing psychologist, as defined, to prescribe drugs for the treatment of specified disorders if certain requirements are met, under collaborative medication treatment management protocols. Drugs that may be prescribed include Schedule II-V controlled substances.
California	Scope of Practice	Amended	SB	1504	Prohibits a pharmacist from filling a prescription order for an antiepileptic drug, or formulation of an antiepileptic drug prescribed by its trade, brand

					brand, or generic name for the treatment or prevention of epileptic seizures, or substitute a drug product without prior notification of the prescriber and the signed consent to the substitution from the patient or the patient's parent, legal guardian, or spouse.
California	Scope of Practice	Failed	AB	1643	Repeals the prohibition against a physician and surgeon supervising more than 4 nurse practitioners at one time.
California	Physician Practice	Pending	AB	2644	Requires any health care provider that directly bills a patient for professional health care services, including hospital services, to provide in plain English, as defined, a description of the medical procedures or services for which a patient is billed.
California	Medical Board Organization & Authority	Pending	AB	2482	Authorizes the Physician Assistant Committee to require a physician assistant licensee to complete continuing education as a condition of license renewal. Prohibits the Committee from requiring more than fifty hours of continuing education every two years.
California	Scope of Practice	Pending	AB	1940	Defines temporary disability for the purposes of special license plates, placards, or temporary placards indicating a person is a disabled person, disabled veteran, or an organization or agency involved in the transportation of disabled persons or disabled veterans, and allows the temporary disability designation to be signed by a physician and surgeon, nurse practitioner, certified nurse midwife, or a physician assistant.
California	Miscellaneous	Amended	AB	1944	Amends existing law that established a pilot project to allow qualified district hospitals to employ a physician and surgeon if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon. Deletes the pilot project and instead authorizes a health care district to employ a physician and surgeon if specified requirements are met and the district does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon.
California	Medical Board Organization & Authority	Amended	AB	2439	Makes a formerly $50 voluntary fee for applicants for issuance or renewal of a physician and surgeon's license to be deposited into the Medically Underserved Account for Physicians mandatory. Provides that at least 15% of the funds collected be dedicated to loan assistance for physicians and surgeons who agree to practice in geriatric care settings or settings that primarily serve adults over the age 65 years or adults with disabilities.

California	Medical Board Organization & Authority	Amended	AB	2442	Deletes statutory reference to the diversion program of the Medical Board, which becomes inoperative July 1, 2008.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
California	Medical Board Organization & Authority	Pending	AB	2443	Requires the Medical Board to establish a program to promote the well-being of physicians and surgeons and would require the program to include, but not be limited to, an examination of wellness education for medical students, postgraduate trainees, and licensed physicians and surgeons.
California	Medical Board Organization & Authority	Amended	SJR	19	Requests all relevant agencies, including the Medical Board of California and the Osteopathic Medical Board of California, to notify California licensed health professionals about their professional obligations under international law which prohibit the torture of, and the cruel, inhuman, and degrading treatment or punishment of, detainees in United States custody. The Legislature further requests that all relevant agencies to notify health professionals licensed in California that those who participate in coercive interrogation, torture, or other forms of cruel, inhuman, or degrading treatment or punishment may one day be subject to prosecution. Be it further resolved that the Legislature further requests that all California-licensed health professionals be removed from participating in any way in prisoner and detainee interrogations that are coercive or enhanced or that involve torture or cruel, inhuman, or degrading treatment or punishment. However, such licensed health professionals may continue to provide appropriate health care if called upon to deal with a victim of the conduct and torture described in this resolution.
California	Medical Board Organization & Authority	Amended	AB	2445	Authorizes the Medical Board to issue a physician's and surgeon's certificate to an applicant who has committed lesser violations, and to

					concurrently issue a public letter of reprimand. The letter of reprimand would be purged three years from the date of issuance.
California	Medical Errors/Patient Safety	Pending	AB	3037	Declares the intent of the legislature to enact legislation that would require the development of an online database with information on the criminal backgrounds of physicians and surgeons.
California	Extending Health Care Services to Underserved Patient Populations	Amended	AB	2543	Establishes the Geriatric and Gerontology Workforce Expansion Act to provide loan repayment assistance to licensed health care professionals, social workers, or marriage and family therapists who work in a geriatric care setting. Requires the selection committee of the Stephen M. Thomson Physician Corps Loan Repayment Program to fill 15% of the available positions with program applicants that agree to participate in a geriatric care setting.
California	Medical Board Organization & Authority	Amended	AB	2734	Requires a public communication by a licensed physician and surgeon to include a valid license number, contact information for the appropriate licensing agency, a notice to contact the agency for further licensing details, and, in the case of an entity other than an individual, the fictitious name permit number, as specified. Prohibits the willful and intentional use of a license number that is not the person's current, valid license number. Violation of these provisions constitutes a misdemeanor and also constitutes unprofessional conduct.

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State	Issue	Status	LegType	Bill Number	Bill Summary
California	Medical Board Organization & Authority	Amended	SB	1441	Establishes the Diversion Coordination Committee within the Department of Consumer Affairs to be comprised of the executive officers of those healing arts boards, including the Medical Board, that establish and maintain a diversion program. The Committee shall issue a set of best practices and recommendations to govern those healing arts licensing boards' diversion programs. The Licensee Drug and Alcohol Addiction Coordination Committee is also established along similar lines.
California	Medical Board Organization & Authority	Amended	SB	1454	Excludes from the exemption that a health care practitioner whose license is prominently displayed in a practice or office to the requirement the health care practitioner disclose, while working, his or her name and license status on a specified name tag, if the health care practitioner is working in an outpatient clinic. Requires the Medical Board to establish, as a priority, the investigation of unlicensed activity or other specified violations in clinics or other settings using laser or intense pulse light devices. Requires the Medical Board to post on its website an easy to understand factsheet to educate the public about cosmetic surgery and procedures. Further, requires the Board to notify the public whether a setting is accredited, certified, or licensed, and requires the accrediting agency to immediately notify the Board if the outpatient setting's certificate for accreditation has been denied.
California	Medical Errors/Patient Safety	Pending	AB	2542	States the intent of the legislature to enact legislation that would enhance patient safety.
California	Outpatient/Office-Based Surgery	Amended	AB	2122	Enacts the Outpatient Surgery Patient Safety and Improvement Act to require, on or after January 1, 2009, any person, firm, association, partnership, or corporation desiring a license for a surgical clinic to meet prescribed operational, staffing, and procedural standards. The Department of Public Health is required to perform periodic inspections of surgical clinics at least once every 3 years.
California	Medical Board Organization & Authority	Pending	AB	2444	Allows the Medical Board to include in a public letter of reprimand, at the discretion of the Board, a requirement for specified training.
California	Electronic & Internet Prescribing	Failed	AB	1	AB 1a Removes the requirement that a medical assistant may administer medication upon specific authorization and supervision of a nurse practitioner, nurse-midwife, or physician assistant; prohibits a physician or surgeon from supervising more than 6 nurse practitioners at one time or from supervising more than 6 physician assistants at one time; creates the Task Force on Nurse Practitioner Scope of Practice who will be

					responsible for developing a recommended scope of practice for nurse practitioners. This bill would also require electronic prescribing systems to meet specified standards and requirements and would require a prescriber to give patients a written receipt of information transmitted electronically, including the patient's name and the drug prescribed, and would require the State Department of Health Care Services to identify best practices related to e-prescribing modalities and standards and to develop a pilot program to foster the adoption and use of electronic prescribing by health care providers that contract with Medi-cal.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
California	Miscellaneous	Pending	SB	1294	Amends existing law that established a pilot project to allow qualified district hospitals to employ a physician and surgeon if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon. Revises the pilot project to authorize a health care district to employ a physician and surgeon if specified requirements are met and the district does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon.
California	Scope of Practice	Failed	SB	993	Authorizes a certified prescribing psychologist, as defined, to prescribe drugs for the treatment of specified disorders if certain requirements are met. Amends the definition of the practice of psychology to include prescribing drugs by a certified prescribing psychologist.
California	Telemedicine	Amended	AB	2661	Provides that telemedicine includes the use of telephonic communication to provide and support health care delivery, diagnosis, consultation, and treatment when distance separates a patient and his or her primary care physician and surgeon. Requires a health care practitioner utilizing telemedicine to create and maintain an electronic medical record on each patient that the practitioner treats via telemedicine. Further authorizes a patient's physician providing health care via telemedicine to prescribe, dispense, or furnish dangerous drugs without a prior examination.

California	Managed Care	Amended	AB	1774	Requires a health care service plan contract and a health insurance policy to provide coverage for any test necessary for the screening and diagnosis of gynecological cancers when ordered by a physician, nurse practitioner, or certified nurse midwife.
California	Managed Care	Amended	AB	2861	Requires a health care service plan or an insurer that provides coverage for emergency health care services to reimburse providers for prestabilization emergency mental health services provided to its enrollees or insureds without prior authorization in specified circumstances.
California	Miscellaneous	Amended	ACR	112	Establishes the Legislative Task Force on Fibromyalgia to perform various functions regarding fibromyalgia as specified, including promoting fibromyalgia education and training programs for physicians and other health professionals.
California	Complementary and Alternative Medicine	Failed	AB	636	Amends the definition of the practice of acupuncture to authorize the use of light by a licensed acupuncturist to promote, maintain, and restore health.
California	Physician Practice	Amended	SB	1729	Requires that all registered nurses, certified nurse assistants, licensed vocational nurses, and physician and surgeons working in skilled nursing facilities or congregate living health facilities participate in a training program that focuses on preventing and eliminating discrimination based on sexual orientation and gender identity.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
California	Medical Board Organization & Authority	Amended	SB	1779	Requires that certain training required for a physician and surgeon's license must be approved by, or in programs approved by, the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada, and deletes the requirement of passage of a clinical competency examination that is currently applicable to certain applicants. Further deletes the requirement that the Board keep state examination records on file for at least 2 years, and instead requires the Board to keep such records on file until June 2069.

California	Extending Health Care Services to Underserved Patient Populations	Amended	SB	1332	Requires seniors and persons with disabilities in certain counties who are not expressly excluded from enrollment to enroll in a Medi-Cal managed care health plan.
California	Medical Errors/Patient Safety	Amended	SB	158	Requires the Department of Public Health to establish a health care infection surveillance, prevention, and control program. Further, the Department is required to adopt hospital staffing regulations for hospital infection surveillance, prevention, and control programs.
California	Medical Board Organization & Authority	Amended	AB	1869	Abolishes the Medical Board of California and other various boards and committees regulating practitioners of the healing arts and transfers all of their respective duties, responsibilities, obligations, liabilities, and jurisdiction to the Department of Consumer Affairs. The Osteopathic Medical Board of California remains a separate entity from the Department.
California	Miscellaneous	Amended	SB	1640	Revises the pilot project to allow qualified district hospitals to employ a physician and surgeon, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon, to authorize the direct employment by general acute care hospitals meeting specified requirements of an unlimited number of physicians and surgeons under the pilot project, and would authorize such a hospital to employ up to five licensees at a time.
California	Miscellaneous	Pending	AB	2821	Repeals the specific annual dollar limit on gifts, promotional materials, or items or activities that may be given or provided by a pharmaceutical company to a physician and instead, prohibits any pharmaceutical company, or agent thereof, from offering or giving a gift, or combination of gifts, that have a total value of more than $250 to a medical or health professional. Every pharmaceutical company would have to annually file a report that identifies all permitted gifts, financial support, payments, honoraria, or other compensation paid to medical or health professionals during the proceeding year.
California	Miscellaneous	Amended	AB	2794	Prohibits a healing arts practitioner from charging, billing, or soliciting payment from any patient, client, or 3rd-party payer for performance of the technical component of specified diagnostic imaging services not rendered by the licensees or persons under their personal supervision.
California	Telemedicine	Pending	AB	2721	Declares the intent of the legislature to create a California Telemedicine

					Task Force to look into telemedicine reimbursement issues and clarify the Telemedicine Act of 1996 to require all payers to provide a payment mechanism for telemedicine and specify their reimbursement policies in writing.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
California	Emergency Preparedness	Amended	AB	64	Enacts the Uniform Emergency Volunteer Healthcare Practitioners Act. The Act would allow a practitioner to volunteer their services during a time of emergency if they are licensed and in good standing in another state. Their licensure status must be verified by a volunteer health practitioner registration system.
California	Medical Board Organization & Authority	Amended	SB	797	Extends certain provisions of the Health Quality Enforcement Section of the Department of Justice and who has the primary responsibility of investigating and prosecuting proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, as inoperative on July 1, 2010, and repeal them on January 1, 2011. The bill specifies that an investigator is not under the supervision of the deputy attorney general simultaneously assigned to the complaint, and would require the medical board to increase its computer capabilities and compatibilities with the Health Quality Enforcement Section.
California	Medical Errors/Patient Safety	Failed	SB	743	Requires every licensed general acute care hospital, licensed acute psychiatric hospital, or special hospital, by January 1, 2009, to conduct an assessment of its processes for detecting, reporting, and remediating preventable medical errors, and to prepare a plan for reducing the prevalence of those errors.
California	Pain Management/Prescription Monitoring	Failed	AB	374	Allows an adult who is suffering from a terminal disease to make a request for medication to obtain life-ending medication to his or her attending physician and states that an attending physician who in good faith compliance with this chapter is not being neglectful of the patient.

California	Telemedicine	Amended	AB	2120	Extends from January 1, 2009 to January 1, 2013, language authorizing the Medi-Cal program to utilize certain telemedicine practices.
Guam	Telemedicine	Pending	B	245	States that a licensed physician who resides outside of Guam is not subject to Guam medical licensure requirements where said licensed physician is providing consultation to a Guam licensed physician through the use of telemedicine technology if certain conditions are met.
Hawaii	Miscellaneous	Amended	HB	2776	Defines physician-patient relationship and requires that, at a minimum, the treating physician or physician's designated member of the health care team personally perform a face-to-face history and physical examination of the patient, makes a diagnosis and formulates a therapeutic plan, or personally treats a specific injury or condition, discusses with the patient the diagnosis or treatment, including the benefits of other treatment options, and ensures the availability of appropriate follow-up care. States that it is unlawful for any person who is a practitioner to predate or pre-sign prescriptions to facilitate the obtaining or attempted obtaining of controlled substances, or who is a practitioner to facilitate the issuance or distribution of a written prescription or to issue an oral prescription for a controlled substance when not physically in the state. Further, it is unlawful for any person to administer, prescribe, or knowingly dispense any controlled substance without a bona fide physician-patient relationship. Any person who violates this section is guilty of a class C felony. Any person who violates this chapter or any rule adopted pursuant to this chapter shall be fined not more than $10,000 for each separate offense as a civil action.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Hawaii	Medical Malpractice	Amended	HB	2151	Establishes the medical malpractice captive insurance company to provide

					medical malpractice insurance coverage to licensed self-employed medical doctors at the lowest possible cost.
Hawaii	Medical Malpractice	Pending	HB	2570	Provides a limitation on noneconomic damages in medical tort actions against a health care provider.
Hawaii	Medical Malpractice	Pending	SB	2354	Provides a limitation on noneconomic damages in medical tort actions against a health care provider.
Hawaii	Medical Malpractice	Pending	HB	2631	Limits noneconomic damages in medical tort actions against a health care provider to a maximum award of $500,000.
Hawaii	Medical Malpractice	Pending	SB	2942	Limits noneconomic damages in medical tort actions against a health care provider to a maximum award of $500,000
Hawaii	Emergency Preparedness	Pending	HB	2424	Creates a section detailing emergency volunteer health practitioner standards, including establishing a system for registering such practitioners.
Hawaii	Miscellaneous	Pending	SB	2928	Prohibits all forms of discrimination, disqualification, coercion, disability, or liability upon such healthcare providers, institutions and payers that decline to perform any health care service that violates their conscience.
Hawaii	Extending Health Care Services to Underserved Patient Populations	Pending	HB	2414	Allows the Department of Health to pay a percentage of the costs of professional liability insurance for a physician with a qualified practice in a health professional shortage area of the state equal to that percentage of the physician's patients residing in a health professional shortage area whose services are compensated by receipts from the Medicaid program.
Hawaii	Miscellaneous	Amended	SB	2460	Defines physician-patient relationship and requires that, at a minimum, the treating physician or physician's designated member of the health care team personally perform a face-to-face history and physical examination of the patient, makes a diagnosis and formulates a therapeutic plan, or personally treats a specific injury or condition, discusses with the patient the diagnosis or treatment, including the benefits of other treatment options, and ensures the availability of appropriate follow-up care. States that it is unlawful for any person who is a practitioner to predate or pre-sign prescriptions to facilitate the obtaining or attempted obtaining of controlled substances, or who is a practitioner to facilitate the issuance or distribution of a written prescription or to issue an oral prescription for a controlled substance when not physically in the state. Further, it is unlawful for any person to administer, prescribe, or knowingly dispense any controlled

					substance without a bona fide physician-patient relationship. Any person who violates this section is guilty of a class C felony. Any person who violates this chapter or any rule adopted pursuant to this chapter shall be fined not more than $10,000 for each separate offense as a civil action.
Hawaii	Managed Care	Pending	HB	2836	Establishes a new, non-judicial external review procedure by which patients may challenge a health plan's final, internal denial of coverage.
Hawaii	Miscellaneous	Pending	HB	2871	Appropriates funds to the University of Hawaii to study the medical efficacy of marijuana in its various forms of delivery, including the reclassification of medical marijuana as a schedule III controlled substance.

Hawaii	Medical Errors/Patient Safety	Pending	HB	2878	Establishes direct care registered nurse-to-patient staffing requirements in health care facilities for the purpose of ensuring patient safety and quality health care.
Hawaii	Medical Malpractice	Pending	HB	3102	Limits noneconomic damages in medical tort actions against a health care provider to a maximum award of $250,000.
Hawaii	Medical Malpractice	Pending	SB	3024	Limits noneconomic damages in medical tort actions against a health care provider to a maximum award of $250,000.
Hawaii	Miscellaneous	Pending	HB	2741	Prohibits all forms of discrimination, disqualification, coercion, disability, or liability upon such healthcare providers, institutions and payers that decline to perform any health care service that violates their conscience.
Hawaii	Extending Health Care Services to Underserved Patient Populations	Amended	HB	2393	Creates the Hawaii Medical Doctor Loan Program to provide financial support to students who complete a state-approved medical school program at the University of Hawaii and who agree to practice in rural areas of the state.
Hawaii	Medical Malpractice	Pending	HB	2161	Establishes the medical malpractice captive insurance company to provide medical malpractice insurance coverage to licensed self-employed medical doctors at the lowest possible cost.
Hawaii	Scope of Practice	Pending	SB	2531	Allows appropriately trained and supervised licensed medical psychologists practicing in federally qualified health centers to prescribe psychotropic medications for the treatment of mental illness.
Hawaii	Scope of Practice	Pending	HB	2411	Allows appropriately trained and supervised licensed medical psychologists practicing in federally qualified health centers to prescribe psychotropic medications for the treatment of mental illness.
Hawaii	Medical Malpractice	Pending	SB	2788	Establishes a two-year medical malpractice court pilot project to test this method of reducing time and expense involved in the litigation of medical malpractice claims.
Hawaii	Medical Malpractice	Pending	HB	2405	Establishes a two-year medical malpractice court pilot project to test this method of reducing time and expense involved in the litigation of medical malpractice claims.
Hawaii	Extending Health Care Services to Underserved Patient Populations	Amended	HB	2519	Requires the legislative research bureau to research the actions, programs, or approaches other jurisdictions have taken to address physician and dentist shortages including student loan repayment and stipend programs. The bureau shall submit a report of its findings and recommendations and any proposed legislation to the legislature not later than twenty days prior to the convening of the regular session of 2009.
Hawaii	Medical Malpractice	Amended	HB	1992	Provides a limitation on noneconomic damages in medical tort actions against a health care provider.
Hawaii	Medical Malpractice	Pending	HB	2232	Limits noneconomic damages in medical tort actions against a health care provider to a maximum award of $250,000.

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State	Issue	Status	LegType	Bill Number	Bill Summary
Hawaii	Medical Malpractice	Pending	HB	2284	Limits noneconomic damages in an action for a medical tort to a maximum award of $500,000 per person or $1,000,000 per occurrence. Damages recoverable for pain and suffering shall be limited in an action for a medical tort to a maximum of $250,000 per person, three times a person's economic loss to a maximum award of $400,000 per person, or $500,000 per occurrence.
Hawaii	Scope of Practice	Pending	SB	1346	Allows a licensed psychologist to perform court ordered mental or other medical observation and examination of a defendant who has been convicted of a felony or misdemeanor.
Hawaii	Scope of Practice	Amended	HB	1260	Allows a licensed psychologist to perform court ordered mental or other medical observation and examination of a defendant who has been convicted of a felony or misdemeanor.
Hawaii	Medical Board Organization & Authority	Pending	HB	3105	Revises laws governing the practice of osteopathy. Requires osteopathic physicians to meet the CME requirements by obtaining credit hours in a category IA CME program approved by the AOA, in a CME activity designated for category I by an AMA accredited provider, or in other approved CME. An applicant for an initial osteopathic license may also take the COMLEX or NBOME examination, or, if from another state, may have passed the COMVEX or SPEX examinations. Amends the definition of unprofessional conduct to include reference to osteopathic physicians.
Hawaii	Extending Health Care Services to Underserved Patient Populations	Amended	HB	2413	Creates an income tax credit for physicians who practice in medically underserved areas.
Hawaii	Scope of Practice	Pending	SB	2415	Allows appropriately trained and supervised licensed medical psychologists practicing in federally qualified health centers to prescribe psychotropic medications for the treatment of mental illness.

Hawaii	Medical Malpractice	Pending	HB	1995	Limits noneconomic damages in medical tort actions against a health care provider to a maximum award of $500,000.
Hawaii	Physician Practice	Pending	SB	2633	Requires every physician to report immediately in writing to the respective county examiner of drivers every patient age fifteen years or older whose dementing illness affects that person's ability to safely operate a motor vehicle.
Hawaii	Complementary and Alternative Medicine	Pending	SCR	198	Requests the Governor, the Director of Health, the Director of Commerce and Consumer Affairs, and all others working in the health care field, to work together to integrate all licensed health care providers, including naturopathic, acupuncture, and eastern medicine practitioners, into the continuum of available health care options for residents of Hawaii. Further, those mentioned above are requested to remove all barriers that may impede the integration of all licensed health care providers into the continuum of available health care options for the residents of Hawaii.
Hawaii	Managed Care	Pending	HR	127	Urges health insurers to provide coverage for fees charged for letters provided by a physician as verification of a patient's disability or other condition for which substantiation is necessary.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Hawaii	Medical Malpractice	Amended	HCR	349	Requests the Legislative Reference Bureau to study the effects of medical tort reform on access to health care, and to review available information concerning the benefits and burdens to states that have adopted medical tort reform, or medical liability reform
Hawaii	Extending Health Care Services to Underserved Patient Populations	Pending	HCR	314	Urges the University of Hawaii to establish a rehabilitative and related services graduate school loan program within its Center on Disability Studies to provide financial support to individuals who complete graduate

					programs in the fields of physical therapy, occupational therapy, speech language pathology, or school psychology, and to provide educational loan forgiveness based upon employment in Hawaii with the State or another qualifying institution following completion of the graduate program.
Hawaii	Medical Board Organization & Authority	Passed	SB	3027	Revises laws governing the practice of osteopathy. Requires osteopathic physicians to meet the CME requirements by obtaining credit hours in a category IA CME program approved by the AOA, in a CME activity designated for category I by an AMA accredited provider, or in other approved CME. An applicant for an initial osteopathic license may also take the COMLEX or NBOME examination, or, if from another state, may have passed the COMVEX or SPEX examinations. Amends the definition of unprofessional conduct to include reference to osteopathic physicians.
Hawaii	Extending Health Care Services to Underserved Patient Populations	Pending	HB	3438	States that any physician, dentist, or licensed health care organization that provides medical or dental care without remuneration or expectation of remuneration to indigent persons shall not be liable for any civil damages related to the free services provided.
Hawaii	Telemedicine	Passed	HR	119	Requests the University of Hawaii John A. Burns School of Medicine's Telehealth Research Institute to form a task force to explore the feasibility of further implementation of the telemedicine systems so that citizens of Hawaii may benefit from it and to examine issues regarding telemedicine. The task force is requested to submit a preliminary report of its findings and recommendations to the Legislature no later than twenty days prior to the convening of the Regular Session of 2009, and a final report of its findings and recommendations, including any necessary proposed legislation not later than twenty days prior to the convening of the Regular Session of 2010.
Hawaii	Complementary and Alternative Medicine	Pending	SCR	197	Requests the Director of Health and the Director of Commerce and Consumer Affairs to recognize that the practice of naturopathy includes the use of injections for administering certain natural medicines and may be performed by a duly licensed naturopathic physician.
Hawaii	Electronic & Internet Prescribing	Amended	SB	1487	States that to establish a physician-patient relationship, the treating physician or the physician's designated member of the health care team, must at a minimum personally perform a face-to-face history and physical

					examination of the patient, make a diagnosis and formulate a therapeutic plan, discuss with the patient the diagnosis or treatment, and ensure the availability of appropriate follow-up care. States that it is unlawful for any person subject to this act except a pharmacist, to administer, prescribe, or dispense any controlled substance without a bona fide physician-patient relationship.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Hawaii	Medical Malpractice	Amended	HB	2291	Requires health insurers, after receiving a claim for the payment of benefits, to make direct payment to the healthcare provider that provided the service and limits the amount of noneconomic damages in medical tort actions.
Hawaii	Managed Care	Pending	HCR	148	Urges health insurers to provide coverage for fees charged for letters provided by a physician as verification of a patient's disability or other condition for which substantiation is necessary.
Hawaii	Medical Errors/Patient Safety	Pending	SB	2781	Establishes direct care registered nurse-to-patient staffing requirements in health care facilities for the purpose of ensuring patient safety and quality health care.
Hawaii	Medical Malpractice	Pending	HB	3361	Limits noneconomic damages in medical tort actions against obstetricians, obstetrician gynecologists, and trauma care providers to a maximum award of $500,000.
Hawaii	Scope of Practice	Amended	HB	3229	Provides for chiropractic coverage under medical assistance programs.
Hawaii	Scope of Practice	Amended	HB	3231	Provides for chiropractic coverage under medical assistance programs.
Hawaii	Pain Management/Prescription Monitoring	Amended	HB	3242	Promotes better quality of life for many individuals through pain relief by clarifying the provisions for prescribing opiate medication for pain treatment. Also stipulates that a schedule II controlled substance

					prescription be filled within seven days of issue, instead of three as currently required.
Hawaii	Pain Management/Prescription Monitoring	Amended	SB	2157	Clarifies a patient's right to be prescribed controlled substances to relieve pain. Also stipulates that a schedule II controlled substance prescription be filled within seven days of issue, instead of three as currently required. Establishes the Hawaii health corps to provide loan repayment for physicians and dentists who agree to work at least five years as a physician in health professional shortage areas of the state, and as first responders during civil defense and other emergencies. Provides stipends for physicians and dentists who agree to provide services in health professional shortage areas of the state, and as first responders during civil defense and other emergencies.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Hawaii	Medical Board Organization & Authority	Pending	HB	3245	Requires the Board of Medical Examiners to create individual profiles on licensees for dissemination to the public. Information to be included in the profiles includes: criminal convictions for felonies and serious misdemeanors within the most recent ten years; final board disciplinary actions in state and elsewhere for the most recent ten years; revocation or involuntary restriction of hospital privileges in the most recent ten years; all medical malpractice court judgments or arbitration awards during the most recent ten years; medical schools and dates of graduation; graduate medical education; specialty board certification; number of years in practice; names of hospitals with privileges; appointments to medical school faculties; publications in peer-reviewed medical literature; professional or community service activities and awards; primary practice setting location; translating services offered; and an indication of whether the licensee participates in the Medicaid program. Also revises the requirements for entities required to report to the board regarding the professional conduct and capacity of physicians and surgeons.

Hawaii	Miscellaneous	Amended	SCR	33	Requests the Department of Health, the Executive Office on Aging, the Department of Human Services, and the State Health Planning and Development Agency to continue their work on the long term living initiative.
Hawaii	Physician Practice	Pending	HB	3353	Requires every health care provider who assumes responsibility for prenatal care of pregnant women and at delivery to test pregnant women for HIV except in cases where the woman refuses the testing. Any person or institution who willfully violates any provision of this section shall be fined not less than $1,000 nor more than $10,000 for each violation.
Hawaii	Extending Health Care Services to Underserved Patient Populations	Pending	SB	2590	Provides an opportunity for physicians who have graduated from the University of Hawaii John A. Burns School of Medicine and completed their residency to repay their debt by serving in rural communities for a total of two years. If a person has obtained a license to practice in another state, that person shall first obtain a license to practice medicine prior to working in the state to fulfill the obligations of this subsection.
Hawaii	Telemedicine	Amended	HCR	138	Requests the University of Hawaii John A. Burns School of Medicine's Telehealth Research Institute to form a task force to explore the feasibility of further implementation of the telemedicine systems so that citizens of Hawaii may benefit from it and to examine issues regarding telemedicine. The task force is requested to submit a preliminary report of its findings and recommendations to the Legislature no later than twenty days prior to the convening of the Regular Session of 2009, and a final report of its findings and recommendations, including any necessary proposed legislation not later than twenty days prior to the convening of the Regular Session of 2010.
Hawaii	Medical Malpractice	Pending	SB	2412	Provides a limitation on noneconomic damages in medical tort actions against a health care provider.
Hawaii	Extending Health Care Services to Underserved Patient Populations	Amended	SCR	35	Requests the Maui Health Initiative Task Force and the Maui Long Term Care Partnership submit the recommendations resulting from their comprehensive needs assessment to the Long Term Care Commission to develop a home- and community-based model of services for Hawaii.

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State	Issue	Status	LegType	Bill Number	Bill Summary
Hawaii	Miscellaneous	Failed	SB	2534	Requires the Board of Pharmacy to develop criteria for a standardized tamper-resistant prescription pad that can be used by all health care providers who prescribe drugs. Further, before December 31 of each year, every pharmaceutical manufacturing company shall disclose to the Board the value, nature, and purpose of any gift, fee, payment, subsidy, or other economic benefit provided in connection with detailing, promotional, or other marketing activities by the company to any physician, hospital, nursing home, pharmacist, health benefits plan administrator, or any other person authorized to prescribe, dispense, or sell prescription drugs.
Hawaii	Extending Health Care Services to Underserved Patient Populations	Pending	SB	2589	Establishes and appropriates funds for a rural medical practice loan repayment program for licensed physicians who participate in the family practice residency program and who commit to practice medicine for five years in rural areas on the neighbor islands.
Oregon	Scope of Practice	Passed	SB	1062	SB 1062a States that a certified nurse practitioner or certified clinical nurse specialist granted the privilege of writing prescriptions may issue prescriptions for controlled substances listed in schedules II through V. Previously, the Board of Nursing issued a formulary for such prescribers.
Oregon	Telemedicine	Failed	SB	1100	SB 1100a States the Director of Human Services may by rule adopt rates and requirements for reimbursing health professionals for telemedical physical health services provided to recipients of state medical assistance. Further, a health insurer must reimburse a person insured under a policy of health insurance for a service provided using telemedicine in certain instances.
Utah	Scope of Practice	Failed	HB	276	Authorizes a physician assistant or nurse practitioner to state or certify cause of death, and complete and sign a death certificate. Further allows a physician assistant or nurse practitioner to certify that a person has a disability for purposes of obtaining a disability special group license plate, a temporary removable windshield placard, or a removable

					windshield placard from the Motor Vehicle Division.
Utah	Emergency Preparedness	Passed	HB	277	Provides that an entity that allows a governmental agency or political subdivision to use its building to provide drugs or vaccines during certain declared public health emergencies is protected from liability during the public health emergency.
Utah	Emergency Preparedness	Passed	SB	66	Enacts the Uniform Emergency Volunteer Healthcare Practitioners Act. The Act would allow a practitioner to volunteer their services during a time of emergency if they are licensed and in good standing in another state. Their licensure status must be verified by a volunteer health practitioner registration system.
Utah	Scope of Practice	Failed	HB	477	Establishes the Anesthesiologist Assistant Licensing Board to license anesthesiology assistants and defines the practice of anesthesiologist assistant.
Utah	Scope of Practice	Passed	HB	399	Amends the definition of practice as a medication aide certified.
Utah	Scope of Practice	Passed	SB	93	Amends the definition of practice of licensed direct-entry midwife.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Utah	Medical Malpractice	Failed	HB	191	Relates to medical malpractice arbitration.
Utah	Telemedicine	Passed	HB	16	States that on or after July 1, 2008, communication by telemedicine is considered face to face contact between a health care provider and a patient under the state's medical assistance program under certain circumstances.
Utah	Miscellaneous	Failed	HB	418	Relates to physician education enhancements.
Utah	Telemedicine	Passed	HB	24	Amends the Digital Health Service Commission Act to remove reference to telehealth and instead focus on digital health services. Digital health services are defined as the electronic transfer, exchange, or management

					of related data for diagnosis, treatment, consultation, educational, public health, or other related purposes.
Utah	Physician Practice	Failed	HB	100	Changes the maximum supply of a controlled substance that may be prescribed at any one time from a 30 day supply to a 90 day supply, and removes the authority of a prescriber to distribute three different post dated prescriptions for the same controlled substance.
Washington	Scope of Practice	Failed	HB	2935	States that in industrial insurance benefits decisions, if the department contracts with a utilization review vendor for physical therapy services and the vendor's recommendation is not received within forth-eight hours of the request, the department shall pay the physical therapy provider for any visits by the injured worker that occur while the vendor's recommendation is pending.
Washington	Miscellaneous	Failed	SB	6302	Requires pharmaceutical manufacturers to disclose to the Board of Pharmacy on each gift, fee, or payment made to recipients in the state, and to submit information on a form and manner determined by the Board, starting January 1, 2009, and annually thereafter. Recipients include health care professionals.
Washington	Scope of Practice	Failed	HB	2497	Repeals limitations on dispensing Schedules II through IV controlled substances for advanced registered nurse practitioners.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Washington	Emergency Preparedness	Failed	SB	6506	Creates the Medical Board for Safety and Quality and dissolves the Medical Quality Assurance Commission. Transfers current duties and powers of the Commission to the Medical Board. Grants the Medical Board the ability to adopt guidelines, rules governing the administration of sedation and anesthesia, sanctioning guidelines, certain programs and policies, and a disaster recovery and business continuity plan. Establishes the method for choosing the Medical Board's executive director and establishes that person's powers. Creates the Medical Professions

					Account within the state treasury and states that the Medical Board is in charge of its own monies. Requires the Medical Board to establish a Physician Education and Improvement Program to improve patient safety and the quality of patient care. Creates the Medical Disciplinary Act with procedures and processes unique to the medical profession and the creation of a separate independent medical review body responsible for ruling on medical disciplinary cases. Establishes the power of the Board to issue summary suspensions, and requires every license holder to report to the Board any conviction, determination, or finding that another license holder has committed an act which constitutes unprofessional conduct. Establishes procedures for retired volunteer medical workers to provide care during an emergency or disaster. Requires applicants for licensure to have completed three years of postgraduate medical training, where the current stipulation is for two years. Requires the Medical Board to establish requirements for each applicant for an initial license to obtain a state background check prior to the issuance of any license. The Board may require an applicant to obtain an electronic fingerprint-based national background check in certain situations.
Washington	Miscellaneous	Failed	HB	2494	Requires the Department of Health to develop a simple medical order form and education program for documenting a person's life-sustaining and emergency treatment preferences which clearly indicates resuscitate or do not resuscitate and other choices for life-sustaining and emergency treatment or related comfort care that shall be followed by emergency medical personnel. Any provider who, in good faith, provides, withholds, or withdraws life-sustaining treatment, emergency treatment including resuscitate or do not resuscitate, or related comfort care from a person in accordance with the directions stated on a medical order form shall be immune from civil or criminal liability, including professional conduct sanctions.
Washington	Scope of Practice	Passed	HB	2475	Allows health care assistants to administer certain vaccines and immunizations under supervision from designated health care practitioners.
Washington	Physician Practice	Passed	HB	2431	Requires all persons licensed or certified to provide prenatal care or to practice medicine to provide information to all pregnant women in their care regarding: (a) the use and availability of prenatal tests; and (b)

					using objective and standardized information: (i) the differences between and potential benefits and risks involved in public and private cord blood banking that is sufficient to allow a pregnant woman to make an informed decision before her third trimester of pregnancy on whether to participate in a private or public cord blood banking program, and (ii) the opportunity to donate, to a public cord blood bank, blood and tissue extracted from the placenta and umbilical cord following delivery of a newborn child.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Washington	Medical Board Organization & Authority	Passed	HB	1103	Revises powers of a disciplining authority. Disciplining authorities shall have the power to consider an application for a license, issue citations and assess fines for failure to produce documents, records, or other items, provide a show cause hearing within fourteen days of request by an affected license holder, and to restrict or place conditions on the practice of new licensees. States that with regard to complaints that only allege that a license holder has committed an act or acts of unprofessional conduct involving sexual misconduct, the Secretary of Health shall serve as the sole disciplining authority in every aspect of the disciplinary process. States that every license holder, corporation, organization, health care facility, and state and local governmental agency that employs a license holder shall report to the disciplining authority when any license holder's services have been terminated or restricted based upon a final determination that the license holder has committed an act or acts that may constitute unprofessional conduct. Authorizes the disciplining authority to order permanent revocation of a license if it finds that the license holder can never be rehabilitated or can never regain the ability to practice with

					reasonable skill and safety. Allows a member of a health profession board or commission to express their professional opinions to an elected official about the work of the board or commission, even if those opinions differ from the Department of Health's official position. Requires the Medical Quality Assurance Commission to conduct a pilot project to evaluate the effect of granting the Commission additional authority over budget development, spending, and staffing, to begin on July 1, 2008, and conclude on June 30, 2013. Requires each applicant for an initial license to obtain a state background check prior to the issuance of any license. The Department of Health may require an applicant to undergo an electronic fingerprint-based national background check.
Washington	Extending Health Care Services to Underserved Patient Populations	Passed	SB	6333	Establishes the Citizens' Work Group on Health Care to examine options for improving access to quality, affordable health care.
Washington	Medical Board Organization & Authority	Failed	HB	2816	Requires the Board of Osteopathic Medicine and Surgery to adopt rules to identify those instruments or categories of instruments that are prohibited for use by an osteopathic physician or surgeon or osteopathic physician's assistant for treatment or diagnostic evaluation. The Medical Quality Assurance Commission is required to adopt similar rules pertaining to a physician or surgeon or physician assistant.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Washington	Medical Board Organization & Authority	Failed	HB	2883	Grants disciplining authorities the ability to grant a license subject to conditions in certain circumstances. Further, a disciplining authority may issue citations and assess fines for failure of a licensee to produce documents, records, or other items within twenty-one days of the request. It may also restrict or place conditions on the practice of new licensees in order to protect the public and promote the safety and confidence in the health care system. Further, surrender or revocation of a license is not subject to a petition for reinstatement. The Secretary of Health is

					authorized to receive criminal history record information that includes nonconviction data for any purpose associated with investigation or licensing and investigate the complete criminal history and pending charges of all applicants and licensees. The Department of Health shall require fingerprints for purposes of conducting a national criminal history records check.
Washington	Medical Board Organization & Authority	Failed	SB	6458	Grants disciplining authorities the ability to grant a license subject to conditions in certain circumstances. Further, a disciplining authority may issue citations and assess fines for failure of a licensee to produce documents, records, or other items within twenty-one days of the request. It may also restrict or place conditions on the practice of new licensees in order to protect the public and promote the safety and confidence in the health care system. Further, surrender or revocation of a license is not subject to a petition for reinstatement. The Secretary of Health is authorized to receive criminal history record information that includes nonconviction data for any purpose associated with investigation or licensing and investigate the complete criminal history and pending charges of all applicants and licensees. The Department of Health shall require fingerprints for purposes of conducting a national criminal history records check.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Washington	Resident Licensure/Minimum Standards for Postgraduate Training	Failed	HB	2906	Creates the Medical Board for Safety and Quality and dissolves the Medical Quality Assurance Commission. Transfers current duties and powers of the Commission to the Medical Board. Grants the Medical Board the ability to adopt guidelines, rules governing the administration of sedation and anesthesia, sanctioning guidelines, certain programs and policies, and a disaster recovery and business continuity plan. Establishes the method for choosing the Medical Board's executive director and establishes that person's powers. Creates the Medical Professions

					Account within the state treasury and states that the Medical Board is in charge of its own monies. Requires the Medical Board to establish a Physician Education and Improvement Program to improve patient safety and the quality of patient care. Creates the Medical Disciplinary Act with procedures and processes unique to the medical profession and the creation of a separate independent medical review body responsible for ruling on medical disciplinary cases. Establishes the power of the Board to issue summary suspensions, and requires every license holder to report to the Board any conviction, determination, or finding that another license holder has committed an act which constitutes unprofessional conduct. Establishes procedures for retired volunteer medical workers to provide care during an emergency or disaster. Requires applicants for licensure to have completed three years of postgraduate medical training, where the current stipulation is for two years. Requires the Medical Board to establish requirements for each applicant for an initial license to obtain a state background check prior to the issuance of any license. The Board may require an applicant to obtain an electronic fingerprint-based national background check in certain situations.

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Washington	Emergency Preparedness	Failed	HB	2906	Creates the Medical Board for Safety and Quality and dissolves the Medical Quality Assurance Commission. Transfers current duties and powers of the Commission to the Medical Board. Grants the Medical Board the ability to adopt guidelines, rules governing the administration of sedation and anesthesia, sanctioning guidelines, certain programs and policies, and a disaster recovery and business continuity plan. Establishes the method for choosing the Medical Board's executive director and establishes that person's powers. Creates the Medical Professions Account within the state treasury and states that the Medical Board is in charge of its own monies. Requires the Medical Board to establish a Physician Education and Improvement Program to improve patient safety

					and the quality of patient care. Creates the Medical Disciplinary Act with procedures and processes unique to the medical profession and the creation of a separate independent medical review body responsible for ruling on medical disciplinary cases. Establishes the power of the Board to issue summary suspensions, and requires every license holder to report to the Board any conviction, determination, or finding that another license holder has committed an act which constitutes unprofessional conduct. Establishes procedures for retired volunteer medical workers to provide care during an emergency or disaster. Requires applicants for licensure to have completed three years of postgraduate medical training, where the current stipulation is for two years. Requires the Medical Board to establish requirements for each applicant for an initial license to obtain a state background check prior to the issuance of any license. The Board may require an applicant to obtain an electronic fingerprint-based national background check in certain situations.
Washington	Physician Practice	Failed	HB	2691	Establishes when it is acceptable and not acceptable for a health care practitioner to refer a patient to a health care entity in which the practitioner owns a beneficial interest.
Washington	Scope of Practice	Failed	HB	2667	Allows a registered nurse to delegate tasks related to diabetes care to registered or certified nursing assistants.
Washington	Scope of Practice	Failed	HB	3018	Defines psychiatric advanced registered nurse practitioner and establishes their scope of practice.
Washington	Scope of Practice	Failed	SB	6334	Authorizes health care assistants to administer certain vaccines and immunizations.
Washington	Extending Health Care Services to Underserved Patient Populations	Failed	SB	6360	Establishes the Joint Legislative Task Force on Primary Care Medical Practice to examine ways to recruit and retain primary care physicians in the state

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State	*Issue*	*Status*	*LegType*	*Bill Number*	*Bill Summary*
Washington	Complementary and Alternative Medicine	Failed	HB	2266	States that nothing prohibits the provision of complementary and alternative health care treatments or the provision of health care advice regarding the human body and its functions by an unlicensed health

					care practitioner, the provision of complementary and alternative health care treatments or the provision of health care advice regarding the human body and its functions by an unlicensed health care practitioner under certain specified conditions, or the provision of complementary and alternative health care treatments or the provision of health care advice regarding the human body and its functions by an unlicensed health care practitioner, as long as each person receiving such services signs a declaration of disclosure that includes an overview of the health care practitioner's education and states that the health care practitioner is not an M.D. or other licensed health care practitioner.
Washington	Medical Errors/Patient Safety	Failed	SB	6734	Establishes a mechanism whereby direct care nurses and hospital management shall participate in a joint process to identify and apply best practices related to patient safety and nurse retention, including nurse staffing. Requires each hospital, by September 1, 2008, to establish a nurse staffing committee to carry out the functions of this chapter.
Washington	Medical Errors/Patient Safety	Passed	HB	3123	Establishes a mechanism whereby direct care nurses and hospital management shall participate in a joint process to identify and apply best practices related to patient safety and nurse retention, including nurse staffing. Requires each hospital, by September 1, 2008, to establish a nurse staffing committee to carry out the functions of this chapter.
Washington	Medical Errors/Patient Safety	Failed	HB	2670	Requires medical facilities to submit a report to the Department of Health when it confirms that an adverse event has occurred, with notification of the event occurring within forty-eight hours, and a report of the event within forty-five days. The Department shall make available to the public the notification of adverse events.

State Issue		*Status*	*LegType*	*Bill Number*	*Bill Summary*
Washington	Resident Licensure/Minimum Standards for Postgraduate Training	Failed	SB	6506	Creates the Medical Board for Safety and Quality and dissolves the Medical Quality Assurance Commission. Transfers current duties and powers of the Commission to the Medical Board. Grants the Medical Board the ability to adopt guidelines, rules governing the administration of sedation and anesthesia, sanctioning guidelines, certain programs and policies, and a disaster recovery and business continuity plan. Establishes the method for choosing the Medical Board's executive director and establishes that person's powers. Creates the Medical Professions Account within the state treasury and states that the Medical Board is in charge of its own monies. Requires the Medical Board to establish a Physician Education and Improvement Program to improve patient safety and the quality of patient care. Creates the Medical Disciplinary Act with procedures and processes unique to the medical profession and the creation of a separate independent medical review body responsible for ruling on medical disciplinary cases. Establishes the power of the Board to issue summary suspensions, and requires every license holder to report to the Board any conviction, determination, or finding that another license holder has committed an act which constitutes unprofessional conduct. Establishes procedures for retired volunteer medical workers to provide care during an emergency or disaster. Requires applicants for licensure to have completed three years of postgraduate medical training, where the current stipulation is for two years. Requires the Medical Board to establish requirements for each applicant for an initial license to obtain a state background check prior to the issuance of any license. The Board may require an applicant to obtain an electronic fingerprint-based national background check in certain situations.
Washington	Scope of Practice	Failed	SB	6756	
Washington	Complementary and Alternative Medicine	Failed	SB	6886	
Washington	Scope of Practice	Failed	HB	3373	

Defines the practice of genetic counseling and requires such practitioners to be licensed by the Department of Health.

Allows health care service practitioners who are not licensed, certified, or registered to provide access to health care services to individuals seeking such services. States that any alternative or complementary health care services that are not customarily within the practice of health professions or not included in the curriculum of the required education for those professions, is outside the scope of the profession and, therefore, outside the scope and jurisdiction of the professional quality assurance commissions or regulatory boards.

States that no person may perform the nada protocol without having an endorsement issued by the Department of Health and establishes the meaning of nada protocol.

State	Issue	Status	LegType	Bill Number	Bill Summary
Washington	Complementary and Alternative Medicine	Failed	SB	6034	States that nothing prohibits the provision of complementary and alternative health care treatments or the provision of health care advice regarding the human body and its functions by an unlicensed health care practitioner, the provision of complementary and alternative health care treatments or the provision of health care advice regarding the human body and its functions by an unlicensed health care practitioner under certain specified conditions, or the provision of complementary and alternative health care treatments or the provision of health care advice regarding the human body and its functions by an unlicensed health care practitioner, as long as each person receiving such services signs a declaration of disclosure that includes an overview of the health care practitioner's education and states that the health care practitioner is not an M.D. or other licensed health care practitioner.
Washington	Scope of Practice	Passed	SB	6739	Defines psychiatric advanced registered nurse practitioner and establishes their scope of practice.

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Appendix IX: Comments About Study

- Comments from Web Page
- Comments about Survey
- Comments about Study Process
- Survey Participant Comments by Question
- Participant Comments via Letters
- Participant Survey Short Answer Responses by Question

Comments from Webpage

[redacted]

February 6, 2008

Re: Public letter of Reprimand CMB April 21, 2000

Dear To Whom It May Concern,

This is in response to disparaging words that have been cast upon me, since my becoming president of the local chapter of the [redacted]. This is a forum for solo and small group practitioners that highlights issues pertinent and of interest to these physicians.

First, my background, I am a graduate of [redacted] residency ob/gyn, June [redacted]. I started my medical practice with [redacted]. In the past 20 years of practice I have been on the active medical staff of four hospitals in the area. This was required at one time in order to accommodate the wishes of my patients who wanted to deliver their babies at different hospitals.

In 1988, I went into solo practice. In about 1990, I was on a tissue committee for [redacted] in which I reviewed a case of [redacted], where there was no indication in his history and physical on the chart for a hysterectomy on a woman in her 30s, and the pathology of the uterus was normal. I questioned him, and he was very angry with me. The committee requested that he make sure in the future that there is an indication for surgery. This one incident was the basis for an attack that lasted almost 5-8 years at his base hospital [redacted] in [redacted].

In 1993, I purchased a second medical practice from a doctor in east [redacted]. I applied for privileges at [redacted] and there was no action for over 5 months. Meanwhile, my pregnant patients, from that office were specifically instructed to go to [redacted], since my privileges were not approved as yet at [redacted]. One day, a patient showed up at [redacted] at 2 am, and I made the decision to attend the delivery, as a "good samaritan". I did not know what else to do. I contacted the president of the medical staff that morning to inform and apologize. Nothing came of this until a week later, when I met with the credentials committee for activation of my privileges. I was welcomed by all the physicians who interviewed me, all except one. [redacted] stated "I recommend that we file an 805 report on him", in reference to the delivery of my patient. He said, "you are young and you have a long time to practice, you had better cross your T's and dot your I's". I did not even know what an 805 was, or that this would ultimately endanger my existence as a physician in private practice. It turns out that [redacted] is a Gynecologist only and does not practice obstetrics. As the years followed, the community was referring a very large proportion of gynecologic surgery cases to me. At [redacted] began reviewing my charts on his own, and in violation of normal processes for peer review. I did not know any better, and I did not really understand the process. The peer review process was diverted from truth, justice, and the true concern of improving quality of patient care. Instead it was, and continues to be used, to drive physicians away that are highly competitive and skilled. I was concerned and stated so, in my letter to the President of the Medical Staff [redacted], "that the Medical Staff Bylaws Rules and Regulations (approved 1/16/95) , section 7.2 relation to "Initiation of Investigation" , that investigative committee was being formed to review a single case in question (case No.[redacted], was being formed not in compliance with this rule, made to insure that there is a valid reason to begin such a damaging allegation and investigation. [redacted] continued to review my obstetrics cases, and was told by the department, that he was not to review such cases, since it was out of his specialty. I did prevail in a first JRC, judicial review committee hearing, but lost in a second. This happened in a period of over 2 years, and there were secret "emergency MEC meetings" where there were only two physicians, one being [redacted]. This culminated in a decision by the "MEC" to review all of my cases! In the end, I lost my privileges, and I did have an 805 report in June [redacted]

[redacted]

I am saddened by this injustice in medical staff peer review processes within hospitals. Many times it is conflict of interest, and many times it is anti-competitive efforts, and sometimes it is just plain ignorance of those participating in the process that has been made unjust. True justice does not prevail when there is a desire to subvert it. True justice is not effected when prudent legal processes are not the technical competence within hospital medical staffs. Too many times "ad-hoc"committees are created to incite a concern that is not for quality of care. Too many times Medical Staff Bylaws are not followed, and justice is subverted.

I am very sorry that this has happened, and I have learned to live with this black mark on my good name. It is not fair, but sometimes in life, things are unfair. So, I live another day, to exalt truth and good will, and to help the forces of good to prevail.

Reference: US Supreme Court Mileikowsky v Tenet
P12. "The Fourteenth Amendment of the United States Constitution provides in relevant part: "No State shall . . . deprive any person of life, liberty, or property, without due process of law." U.S. CONST., AMEND. XIV."
p20. "This Amendment(XIV) guarantees due process for property interests established by, and deprived pursuant to, state law. Privileges at hospitals are established property interests under California law..."
p21. "Established as a property interest by California law, see infra Point I.A, hospital privileges can only be deprived in compliance with procedural safeguards of the Fourteenth Amendment." and "Where, as here, the property interest is established, the Fourteenth Amendment precludes deprivation of that interest without due process, which includes the right to be heard by counsel."
p23 "The right to due process 'is conferred, not by legislative grace, but by constitutional guarantee."

Jean A. Seago

From: [redacted]
Sent: Tuesday, May 27, 2008 3:50 PM
To: Jean A. Seago
Cc: [redacted]
Subject: FW: Rebuttal to Unethical Peer Review and Damage Caused

Attachments: [redacted]

Here's the next one.

Thanks,

[redacted]
Lumetra
1 Sansome Street
San Francisco, CA 94104-4429
Telephone: (415) 677-8458
E-mail: [redacted]

-----Original Message-----
From: [redacted]
Sent: Thursday, February 07, 2008 12:33 AM
To: mbc
Subject: Fwd: Rebuttal to Unethical Peer Review and Damage Caused

>> Hello Dr Seago / Lumetra Study,

Please beware that the process of peer review is killing medical professional lives due to abuse of the process.
Please make sure the Lumetra study is taking this into account.
>>
>> I am sending a rebuttal that I have just submitted to the Medical
>> Board Regarding my case in [redacted].
> I did not know that I could submit a rebuttal. Please be aware that
> the incidence of unethical peer review is rampant.
> The problems arise from the lack of oversight, enforcement, and
> penalties for conducting unethical peer review.
> In my case it was an anti-competitive action on a single physician's
> part. This process has destroyed the lives of many physicians, their
> professional lives are their lives.
> I have a "public letter of reprimand" still being posted on the
> California Medical Board. This is so unfair!
> This is coming to haunt me now that I am the [redacted]
> [redacted]
> Our mission is to represent issues for these physicians on a local and
> state level. I am hearing horrible smears of my good name.
>>
>> CMB Case [redacted]
>> [redacted]
>>
>> Please be aware that unethical peer review continues at [redacted]
>> [redacted].

>> Dr [redacted] is the main culprit in my Sham peer review, and the
>> damage caused to my reputation.
>> He continues with his abuse of the peer review system.
>>
>
> If you might want to discuss this, please call me.
>
>> Thanks
>> [redacted]
>>
>>

Jean A. Seago

From: [redacted]
Sent: Tuesday, May 27, 2008 3:50 PM
To: Jean A. Seago
Cc: [redacted]
Subject: FW: peer review

Hi Jean Ann,

[redacted] asked that I send you whatever emails were in the MBC email inbox. We only have two. This is one. I'll forward the other one next.

Thanks,

[redacted]
Lumetra
1 Sansome Street
San Francisco, CA 94104-4429
Telephone: (415) [redacted]
E-mail: [redacted]

From: [redacted]
Sent: Thursday, May 15, 2008 11:45 AM
To: mbc
Subject: peer review

To Whom it May Concern,

I have grave concerns regarding PEER review. I would like to share this information with you in full and you may contact me for details.
The summary:
I was a physician with [redacted] and I took legal action for a breach of contract dispute with them. It was a 3 year to partnership dispute in which I worked for low pay as my buy-in. In 2 and a half years at [redacted], I had never had a QA or peer review. When I left [redacted] Hospital, I had a letter from the CEO inviting me to reapply at any time in the future. In applying to another hospital, I had a letter EIGHT MONTHs after I left stated that there was NO Derogatory information in my file. In deposition of the person in the credentials department over a year and a half later after I left there was no derogatory information. Yet in recently application to [redacted] for license.. there was reported PEER review information that was derogatory (this is a SHAM and there never was a peer review process). I believe this was in retaliation for my breach of contract action, retaliation for my husband reporting DEA violations in the same hospital in which he too worked and in retaliation for my reporting of HIPAA violations.

An unfair peer review process discourages the physician from reporting violations of law due to risk to their own credentials.. and unfairly creates harm to the community potentially decreasing access to care.

I have worked since leaving [redacted] for 3 years with no QA, no peer review and the respect of the current medical community in which I work. I was awarded the AIR FORCE COMMENDATION

MEDAL prior to my working in [redacted]. I am an excellent radiologist with advanced training, fellowship in MRI, as well as academic background teaching Radiology Residents.

Please voice your concerns to the Medical Board of California.. PEER review should not be political. The process MUST be fair and should rely on concrete evidence. SHAM peer review must be stopped.

[redacted]

Comments about Survey

[redacted]

January 30, 2008

[redacted]

Via facsimile

Jean Ann Seago, PhD,RN
Project Consultant
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104

Re: **Peer Review Study – Proposed Survey**

Dear Dr. Seago:

The questions contained on the Peer Review Study Questionnaire have been reviewed and for the reasons stated below, we have advised [redacted] not to forward the questionnaire as requested.

In general, the questionnaire presents an incorrect understanding of such key legal concepts as "peer review body" and statutory reporting obligations. It also seeks information which in some cases has already been provided and in other cases is not maintained in the manner requested. In multiple sections, questions are unclear, provide insufficient information to respond, make assumptions that are erroneous or incomplete, seek information from persons who would not have access to such information, and/or omit from listed responses what may be the most common responses, making some questions unanswerable or readily misunderstood, and potentially resulting in inaccurate responses. The questionnaire also solicits speculation, self-serving characterizations of the peer review process from

reviewed physicians and their legal counsel. And, it requests disclosure of both proprietary information and confidential attorney client information.

As such, no further response will be forthcoming until the above issues have been rectified.

If you need to further discuss the above, please contact the undersigned.

Sincerely,

[redacted]

[redacted]

January 28, 2008

Jean Ann Seago, Ph.D., R.N.
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

RE: Peer Review Study – Proposed Survey

Dear Dr. Seago:

Thank you for sending me a copy of your Peer Review Study Questionnaire. I have reviewed the questions and, for the reasons stated below, have advised [redacted] not to forward the questionnaire as requested.

In general, the questionnaire presents an incorrect and confusing understanding of such key legal concepts as "peer review body" and statutory reporting obligations. It also seeks information which in some cases has already been provided and in other cases is not maintained in the form requested. In multiple sections, questions are unclear, provide insufficient information to respond, make assumptions that are erroneous or incomplete, seek information from persons who would not have access to such information, and/or omit from listed responses what may be the most common response, making some questions unanswerable or readily misunderstood, and potentially resulting in inaccurate responses. The questionnaire also solicits speculation, self-serving characterizations of the peer review process from reviewed physicians and their legal counsel. And, it requests disclosure of both proprietary information and confidential attorney client information.

The foregoing issues appear in the following sections:

Parts One and Two: Composition and Structure of the Peer Review Body and Peer Review Member Selection.

Much of the information solicited in this part is contained in the facility's peer review policy and procedure and medical staff bylaws which have been already been provided Questions sometimes assume information that is inconsistent with these documents that you already were provided. This section also uses a confused and misleading concept of "peer review body and calls for speculation. Most particularly, in Part Two the

questionnaire asks respondents to speculate about both recruitments and motives. Information solicited in several questions is not recorded or tracked.

Part Three: Peer Review Process and Activities

Much of the information solicited in this part is in the facility's peer review policy and procedure and medical staff bylaws that already were provided to you. This section of the questionnaire seriously confuses and misstates the relationship between statutory reporting and events or situations subject to peer review. Responses would not produce useful information and presenting these questions would confuse and mislead those asked to respond. It also reflects an incorrect and misleading view of both peer review committee activity and the process of elevating matters from routine to focused review or to disciplinary action. This section requests information about statutory reporting from individuals who are not obligated to report, may rely on advisors in evaluating reportability and may not be familiar with the details of such reporting. Questions have a high probability of soliciting inaccurate responses by not including in the list of responses (except as "other") at least one of the most frequent concerns that may be the basis for decisions.

Parts Four and Five: Time and Resources Utilized on Peer Review Reporting and Time and Resources – Section 809 Hearings.

This section calls for information to be reported in categories not used or tracked by the facility. It asks for proprietary budgeting information and confidential attorney client information. It also solicits information from individuals not likely to be privy to the information requested.

I would be willing to recommend that the facility provided a narrative description of the time and cost of its peer review, credentialing, quality improvement and related processes.

Part Six: Use of Section 805 Report.

This section confuses the stages in which motives may be an issue and solicits speculation. This is particularly troubling when the questionnaire asks individuals to respond who would have a personal or professional interest in mischaracterizing the peer review and reporting processes.

Part Seven: The Medical Board of California

This section solicits speculation from individuals who may have little or no actual involvement with the Medical Board.

I would be pleased to provide a narrative of my own impressions of the Medical Board's effectiveness. And, I would also recommend that leaders in the facility's peer review activities do likewise.

Part Eight: Section 809 Hearings.

This Section asks individuals to provide details of the statutory process who likely rely on advisors for such information. I would be pleased to provide a narrative of my own impressions about the efficiency and effectiveness of Section 809 hearings. And, I would also recommend that leaders in the facility's peer review activities do likewise.

Part Nine: Recommendations for Improving the Process.

This section presents lists of options that do not include what may be the most common response, likely resulting in confusion about the question or inaccurate responses. It also presents general questions that need additional information in order to respond, or which will result in substantially different responses based upon each respondent's undisclosed assumptions. I would be pleased to provide a statement of my recommendations and would advise leaders of the facility's peer review process to do likewise.

[redacted]

If you need to further discuss the above, please contact the undersigned.

Sincerely,

[redacted]

[redacted]

[redacted]

January 28, 2008

BY EMAIL ATTACHMENT
jseago@Lumetra.com

Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Peer Review Study – Proposed Survey

Dear Ms. Seago:

Thank you for sending me a copy of Lumetra's Peer Review Study Questionnaire. I have reviewed the questions and, for the reasons stated below, have advised [redacted] not to forward the questionnaire as requested.

In general, the questionnaire presents an incorrect and confusing understanding of such key legal concepts as "peer review body" and statutory reporting obligations. It also seeks information, which in some cases has already been provided and in other cases is not maintained in the form requested. In multiple sections, questions are unclear, provide insufficient information to respond, make assumptions that are erroneous or incomplete, seek information from persons who would not have access to such information, and/or omit from listed responses what may be the most common response, making some questions unanswerable or readily misunderstood, and potentially resulting in inaccurate responses. The questionnaire also solicits speculation, self-serving characterizations of the peer review process from reviewed physicians and their legal counsel. And, it requests disclosure of both proprietary information and confidential attorney client information.

[redacted]

The foregoing issues appear in the following sections:

Parts One and Two: Composition and Structure of the Peer Review Body and Peer Review Member Selection.

Much of the information solicited in this part is contained in the facility's peer review policy and procedure and medical staff bylaws, which have already been provided.

Questions sometimes assume information that is inconsistent with these documents that have already been provided to you. This section also uses a confused and misleading concept of "peer review body and calls for speculation. Most particularly, in Part Two the questionnaire asks respondents to speculate about both recruitments and motives. Information solicited in several questions is not recorded or tracked.

Part Three: Peer Review Process and Activities

Much of the information solicited in this part is in the facility's peer review policy and procedure and medical staff bylaws that already were provided to you. This section of the questionnaire seriously confuses and misstates the relationship between statutory reporting and events or situations subject to peer review. Responses would not produce useful information and presenting these questions would confuse and mislead those asked to respond. It also reflects an incorrect and misleading view of both peer review committee activity and the process of elevating matters from routine to focused review or to disciplinary action. This section requests information about statutory reporting from individuals who are not obligated to report, may rely on advisors in evaluating reportability and may not be familiar with the details of such reporting. Questions have a high probability of soliciting inaccurate responses by not including in the list of responses (except as "other") at least one of the most frequent concerns that may be the basis for decisions.

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This section calls for information to be reported in categories not used or tracked by the facility. It asks for proprietary budgeting information and confidential

attorney client information. It also solicits information from individuals not likely to be privy to the information requested.

I would be willing to recommend that the facility provided a narrative description of the time and cost of its peer review, credentialing, quality improvement and related processes.

Part Six: Use of Section 805 Report.

This section confuses the stages in which motives may be an issue and solicits speculation. This is particularly troubling when the questionnaire asks individuals to respond who would have a personal or professional interest in mischaracterizing the peer review and reporting processes.

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This section solicits speculation from individuals who may have little or no actual involvement with the Medical Board.

I would be pleased to provide a narrative of my own impressions of the Medical Board's effectiveness. And, I would also recommend that leaders in the facility's peer review activities do likewise.

Part Eight: Section 809 Hearings.

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Part Nine: Recommendations for Improving the Process.

This section presents lists of options that do not include what may be the most common response, likely resulting in confusion about the question or inaccurate responses. It also presents general questions that need additional information in order to respond, or which will result in substantially different responses based upon each respondent's undisclosed assumptions. I would be pleased to provide a

statement of my recommendations and would advise leaders of the facility's peer review process to do likewise.

Very truly yours,

[redacted]

cc: [redacted]

[redacted]

[redacted]

Comments about Study Process

[redacted]

March 3, 2008

VIA E-MAIL

Jean Ann Seago, Ph.D., R.N.
Project Consultant
Lumetra
One Sansome Street, Suite 600
San Francisco, CA 94104-4448

Re: Comprehensive Study of the Peer Review Process in California

Dear Dr. Seago:

This letter is in response to your request that we provide a narrative of our own impressions about the efficiency and effectiveness of Section 809 hearings, the Medical Board of California's effectiveness, and recommendation for improving the process.

I. The hearing process has become extraordinarily protracted, expensive, and burdensome for medical staffs and hospitals.

Particularly if there are several cases or incidents to prove to demonstrate a trend of problematic care or conduct, a hearing can extend for multiple years. Since hearings must be scheduled when the many participants (e.g. affected practitioner, medical staff presenter, witnesses, panel members, hearing officer) are available, there may be only one or two sessions a month that a hearing can be scheduled. These sessions primarily are at night, after the physician participants' workday, when there are only a few hours available. After scheduled, sessions oftentimes are cancelled or continued if one of the necessary participants becomes unavailable or a physician has not complied with discovery requirements. A hearing officer recently advised that he was involved a hearing that spanned 17 years. Although this is outrageous, multi-year hearings are common.

The current system encourages the practitioner to delay the procedure to then delay the 805 report. Unless a matter is summarily imposed, there is no 805 report until the proposed discipline is upheld through the hearing process. If there is a reasonable possibility the discipline will be upheld and then reported, the physician benefits by continually requesting continuances, not responding to discovery requests so that the medical staff then needs a continuance, and generally moving slowly through the process. One attorney for an affected practitioner advised that he

[redacted]

believed he might be guilty of malpractice if he did not slow the process to delay the outcome and the potential reporting. Delaying the process also increases the chances the panel members will not continue to serve and the hearing then aborted. Given the present uncertainty in the law regarding the hearing officer's authority to impose sanctions for delays and the hearing officers' financial interests in the hearing continuing, medical staffs feel helpless and victimized by the delays and the risks it then imposes of losing the panel.

Medical Staff presenters, who usually attend all of the sessions, frequently complain of the time the hearing takes from their practices. Presenters formerly used to volunteer their time. Now, it is difficult to obtain a presenter even when there is an offer to pay the presenter. Similarly, panel members, who also frequently are volunteers, may drop out and jeopardize the hearing or demand compensation to remain. It is increasingly difficult to find panel members who are willing to serve, even if paid. And, once having served on a panel, most physicians refuse to ever do so again.

Hearings have become exceptionally expensive. Given the complexity of the hearing process and the increasing litigation that challenges the hearing process, medical staffs incur substantial legal fees to have attorneys help assure the process will be defensible if challenged. Opposing counsel or combative physicians, drive up these costs by increasingly try to create procedural issues to potentially challenge an action on a procedural grounds when they realize they will be unable to prevail by challenging the substantive basis. The attorneys' fees are in addition to the hospital's or medical staff's expense for a hearing officer (usually a lawyer), court reporter, transcripts, and the potential payments to the hearing panel to not lose the panel. After the hearing process, medical staffs and hospitals may need to defend the process and the outcome before the governing board and through the courts. Costs for this entire process frequently are in the hundreds of thousands of dollars, and are known to have exceeded a million dollars.

For smaller hospitals that only infrequently have hearings, a hearing is an extraordinary event that requires substantial support from the medical staff office personnel who already are committed to other functions. This staff supports the hearing process, looking for documents, coordinating scheduling and other preparations, and attending the hearing to respond to requests from hearing panels and hearing officers. This time is frequently at the expense of other necessary support for the medical staffs' ongoing quality and peer review processes.

[redacted]

II. The Hearing Process and Stigma of an 805 Report Distort Decision making Regarding Appropriate Disciplinary Action.

Given the time and costs of a hearing, both the medical staff and hospital try to fashion corrective measures that do not trigger a hearing. As you know, many hospitals are financially struggling. On one occasion, the hospital chief executive officer pleaded with the medical executive committee to reconsider a proposed disciplinary measure as potentially triggering a hearing. He advised of the hospital's current financial status and said the hospital could not afford a hearing and litigation that would follow. The medical executive committee then tried to fashion a remedy to avoid a hearing. The remedy then may not have been as effective at addressing the concerns.

In addition to formulating corrective measures to avoid hearings, medical staffs try to avoid a sanction that causes the 805 report. Medical Staffs tend to believe that an 805 report may be a career destroying event. Although the medical staff may know there is an issue that needs to be addressed, if the care is not horrific, they will try to fashion a remedy that will not be reportable. For example, if a member is having poor outcomes in a type of surgery, but the cause is unclear, the medical staff may believe that it would be most effective to proctor, giving the possibility of making suggestions to the physician and of intervening if necessary. However, since proctoring is reportable (and triggers hearing rights), medical staffs may avoid this effective measure, merely suggesting to the doctor that he consider having assistants or take a class. Since assistants may not be reimbursed for the type of case, and education likely is not immediately available, the remedy then is less effective at protecting patient care and addressing the problem, but avoids reporting for a less significant problem that the medical staff does not believe should trigger an 805 report.

III. When the Medical Board Delays in Responding to an 805 Report or Does Not Disclose Information, Medical Staffs are Discouraged from Invoking the Reporting Process.

If a medical staff has made the difficult decision of imposing reportable discipline, and potentially having a hearing, they are discouraged when they believe there has been no action taken by the medical board and that the physician who they believe is dangerous continues to practice. Although it may be aberrational, two particular cases are recalled. In one, a medical staff questioned whether they should waive confidentiality when they determined a specialist member had committed gross misconduct but the physician had no apparent action taken against his license for several years and the Medical Board's publicly available information continued to

[redacted]

state the member was in good standing. (Although the medical staff ultimately was informed that the physician had agreed not to practice, this information was deemed confidential and not available to the public.) In another, a call was placed to the Medical Board when there was no request for medical records or other information for over a year after the medical staff had decided to submit a lengthy 805 to try to alert the Medical Board of a very significant problem that included a patient death.

IV. The Process Needs Improvements.

Given the above, there are several suggestions. It is not known how the Medical Board prioritizes the many matters it reviews for potential discipline. However, since an 805 report is usually the result of prior medical staff review and the medical staff's "last resort" after considering other alternatives, 805 reports should get the top priority for review by the Medical Board.

An alternative non-805 reporting mechanism should be considered to allow intermediate measures. Noting the example above, proctoring should not be reportable as a very limited but valuable option that currently is discouraged by the reporting requirements. Similarly, a short term requirement for an assistant or a consult is a valuable tool that is frequently avoided because it is reportable. Perhaps there could be a two step system implemented, similar to the 821.5 reporting. Under this scenario, the Medical Board might be alerted that a review is underway via a confidential report. The disciplinary branch of the Medical Board and other facilities would not be notified via an 805 Report unless the action remains in effect for an extended period of time or results in further disciplinary action.

The current statute needs clarification. At least one deputy attorney general interpreted the current statute as requiring a report regardless of how long a restriction is in effect, even though it includes language that requires a minimum duration for certain actions to be reportable. He then sent warnings of potential future enforcement for failure to report per his interpretation. It should be confirmed that short term restrictions should not be reportable. If restrictions or suspensions are short term, the problem apparently was resolved without requiring continued discipline. Similarly, it should be confirmed that requiring education or other remedial measures is not a restriction of privileges, such that it is not subject to a hearing or reporting. The Medical Board should have a process to discuss whether proposed actions are reportable, rather than only having this discussion available in the enforcement process. Given conflicting opinions regarding what

[redacted]

is reportable, the Medical Board's refusal to discuss what is reportable (except in the enforcement process), and the penalties for not reporting, medical staffs hesitate to impose and then forego effective remedial measures that are may not be reportable for fear they may be deemed reportable.

As noted above, the duration of hearings and the delays are counter-productive as deterring disciplinary action and delaying reporting. If the current 809 process is retained, it needs revisions to not permit continual delays and to give the hearing officer clear authority to impose sanctions and an impetus to expedite the process.

Since hospitals cannot afford the hearings, but the current reporting system is for the public's benefit, it is questioned if there needs to be another method of funding or handling this process. It would be appealing to have extra-hospital peer review panels that would do hearing processes for all medical staffs. However, given the disparity of quality and varying tolerance for disruptive conduct as between hospitals in a community, some mechanism would need to be available to address and respect these differing standards or to allow those medical staffs who believe they have higher standards and want to conduct their own hearings to continue to do so.

Sincerely,

[redacted]

[redacted]

Survey Participant Comments by Question

Please identify your title in the Peer Review Body. Title_Other

- Chief of Staff
- Chief of Staff
- Chief of Staff and Chair of Med Exec Committee
- Chief of Staff, Chair of MEC
- Chief of the Medical Staff 2007-8
- Medical Director Performance Improvement and Risk

The major/final Peer Review Body in this organization is called: Name_Other, NPS_Name_Other, RP_Other

- Ethics Committee
- We have Medical Review and Surgical review committees
- Question is unclear in that peer review committees by department report to a quality committee called Quality Resource Management (QRM) which is multidisciplinary.....while this is the major committee another report is submitted to the med exec committee which might be considered final at this hospital
- Medical Advisory Committee
- MEC
- Board of Directors
- Each Department has a "peer review" committee, called the Quality Assessment & Improvement Committee. Its reports and findings are reported to the Medical Executive Committee via their Department Chair. There is not just one "Peer Review Body" so it is
- Ethics Committee
- Governing Body has final authority
- I understand the term Peer Review Body to mean any committee which conducts peer review,
- Medical Advisory Committee
- Mills-Penisula Board of Directors
- Note that the hospital's governing board reviews and takes the final action based upon the recommendations of the MEC. For purposes of this survey, the following questions will be answered with regard to the MEC (Medical Executive Committee).
- Our peer review starts at the Department level and depending on the categorization goes to the Medical Staff QA Committee and the Medical Executive Committee.
- Physician Quality Committee
- Please note that the hospital's governing board reviews and takes final action on the recommendations of the Medical Executive Committee (MEC). For purposes of this survey, the following questions will be answered with regard to the MEC.
- Please note that the hospital's governing board reviews and takes the final action based upon recommendations of the Medical Staff Executive Committee. For purposes of this survey, the following questions will be answered with regard to the Medical Staff
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- Please note the hospital's governing board reviews and takes the final action based upon recommendations of the Medical Staff Executive Committee. For the purpose of this survey, the following questions will be answered with regards to the Medical Staff
- Quality Assessment and Improvement Committee

- Quality Committee of the Board
- Systems Review
- The Credentialing department initiates a list of the physicians due for their peer review
- The medical group is part of an integrated delivery system with a hospital. The hospital's Medical Staff performs peer review on behalf of the Medical Group. While the hospital's governing board reviews and takes the final action on most peer review re
- There are six medical staff departments and peer review is conducted within those departments by committee members
- This question is unclear as to "major/final" and "check ALL that apply". Of the committees checked, the MEC is the "major/final", and will be the "Peer Review Body" referred to in all subsequent questions of this survey. Membership on the MEC in our term
- I am a member of the Physician Advisory Group. We do review credentials and discuss problem with physicians but I believe there is also a peer review committee.
- Medical advisory committee
- Medical advisory committee
- Multidisciplinary Peer Review Committee
- Performance improvement committee
- Performance Improvement Committee
- Physician Advisory Group
- Subgroup of MEC- multidisciplinary

What are the types of specialties that are represented on the committee? Spec_Other
NPS_Spec_Other

- Ophthalmology Cardiothoracic surgery urology otorhinolaryngology neurology
- Pathology
- Orthopedics
- Ours is not a medical group - we have none of these specialties
- Cardiac Surgery
- Pathology
- Pathology Orthopedics
- Orthopedics/Podiatry, Pathology, Pulmonary/Critical Care
- Surgical subspecialty (Uro, ortho, ENT, Ophth) Continuing Care,
- Dermatology, Head and Neck surgery, ophthalmology, pathology, cardiology, infectious disease
- Orthopedics, other specialty departments on an ad hoc basis
- Oral and Maxillofacial Surgery
- Pathology,
- Nephrologist, Neurologist, Ophthalmologist
- Neurologist, Ophthalmologist, Nephrologist
- Each Surgical subspecialties ENT, Plastics, Urology Also Critical care
- As note each department does peer review or has a representative although based on the size of the departments Neuro, PM&R and Psych as an example may report to Medicine committee which is also comprised of both IM and FP.... all departments are also represented in the QRM committee
- Pathology
- Pathology, Neurology, Dermatology, Ophthalmology, Head and Neck Surgery, Allergy, Urology, orthopedics
- Orthopedics
- Cardiology, intravascular interventionalist, laboratory/pathology
- Preventive Medicine
- PATHOLOGY
- Preventive Medicine
- Again, each department has a multidisciplinary "peer review" committee, made up of all specialties within the department. There is not just one committee.
- All are non-medical

- All of clinical departments have a peer review committee; I did not answer the top section because we have several peer review committees.
- All specialties represented as each dept/section conducts own peer review
- Allergy, urology, dermatology, physical medicine
- Bariatrics
- Cardiologist, Oncologist
- Cardiology
- Cardiology, Ophthalmology, Orthopedics, Pathology, Physical Medicine & Rehabilitation, Podiatric Surgery
- Cardiology, Orthopedics, ENT, Endocrinology
- CRITICAL CARE SPECIALISTS
- Dentistry, Ophthalmology
- Extended Care (Urgent Care) Surgery includes general surgeon and orthopedic surgeon
- Gastroenterologist
- Hematology/medical oncology
- IM subspecialty GI
- Internal Medicine Subspecialties (Neurology, Nephrology, Rheumatology, Cardiology)
- May assign specialty ad hoc member depending on issue being reviewed.
- Medical Staff Bylaws define membership of the Medical Executive Committee
- Nero, PhD
- Oncology & allergy
- Oncology, Allergy
- Oncology, Cardiology, ENT
- One specialty per department/committee
- Ophthalmology ENT Oncology
- Ophthalmology, Pain Management
- Ortho, GI, Critical Care, Pulmonary, Pathology,
- Orthopedics
- Other departments represented: Orthopedic Surgery, Psychiatry, Podiatry, Cardiovascular Medicine/Surgery
- Pathology
- Pathology
- Pathology and Radiation Oncology
- Pathology, GI, Geriatrics, Orthopedics
- Podiatry Physical Medicine & Rehabilitation
- Psychiatry has been represented in the past but is not currently. The composition is currently under review as part of the review of the Bylaws.
- Pulmonary Medicine
- Pulmonary, Cardiologist,
- Pulmonary, cardiology
- Rheumatology; Otolaryngology; GYN Surgery, Oncology
- Surgery is general surgery and orthopedics representation.
- The final Peer Review Body, prior to Board of Trustees oversight, is the Executive Committee, which is comprised of various service and committee chairs as well as the Chief of Staff and Vice Chief of Staff.
- The Medical Staff Bylaws do not require specific specialty representation on the committee, and the composition varies from time to time following elections and appointments.
- The Medical Staff Bylaws do not require specific specialty representation on the committee, and the composition varies from time to time following elections and appointments.
- Trauma, Pathology
- Urgent Care
- Urology
- We do not offer Pediatrics or Obstetrical service

- Pathology
- Pathology

Schedule of committee meetings: How often does this peer review body meet? Meet_Sched_Other NPS_Meet_Freq_Other

- We rarely meet face to face, but engage in email discussions on an ad hoc basis
- Every second month or more often if needed
- Initially every month, now as needed
- 4-6 times per year
- 4-6 times per year
- 6 times/year
- Ad hoc
- Ad Hoc meetings are held as needed.
- As needed
- Bi-monthly
- Bi-monthly
- Bi Monthly
- Bimonthly
- Depends on the committee meeting schedule but at least every other month.
- Each peer review body varies in frequency of meetings
- Every other month
- Every other month or as needed.
- It varies by Section/Department. The larger groups meet once a month and the smaller sections every other month.
- MEC meets monthly and in addition, as needed however Peer Review is done throughout the various medical staff committee meetings throughout the month.
- Monthly and as otherwise needed.
- Monthly or as needed.
- Monthly, or as needed.
- Monthly, with the exception of August and December
- Most of our peer review committee meetings meet monthly.
- Or as needed
- Or as needed
- Or as needed.
- Some meet monthly; others meet every other month.
- Ten times per year and at call of Chief of Staff
- Ten times per year and at the call of the Chief of Staff
- There is not one body – depends

Indicate the methods used in recruiting members to the Peer Review Body Recruit_Other_Com, NPS_Recruit_Other_Com

- Certain specialties required by hospital bylaws and we choose chiefs of service to sit on committee.
- Department Officer obligation
- Election
- Medical staff leadership positions
- Service chiefs (or designees) and others named in bylaws.
- According to bylaws: Various Chairs of medical staff committees including medical staff officers as well as members of the administrative staff but these members are ex-officio without right to vote.
- Active member's that attend the committee meeting
- Administrative paid service line physicians directors sit on most of the peer review committees but not paid at the level of MEC

- Appointment by Board
- By-Laws require members of the Active Medical Staff to participate in section/department activities, including peer review.
- By appointment
- Each of the Medical Staff Department Chairs sit on the Medical Executive Committee, and each of those Chairs are elected by their respective departments.
- Elected
- I am assuming the term 'peer review body' means the Medical Executive Committee. Members are recruited based largely on interest, willingness to serve and expertise.
- Medical Staff Leadership positions
- Member of the dept/section
- Members of MEC are elected by the Departments. Officers are elected by the active medical staff members. The medical staff gives monthly stipends to the officers.
- Members of the Medical Executive Committee are elected. At the Department level all members participate in peer review as part of responsibilities of being a member of the medical staff. Some physicians participate to a greater level due to interest and
- Members to the Medical Executive Committee are nominated and elected to that position. Term is from July 1st of 2007 to June 30th of 2008.
- Payment is offered for Past Chief of Staff, current Chief of Staff, Chief of Staff Elect & Vice Chief of Staff
- Payment is provided to elected Chief of Staff. Other members are elected department chairs, elected officers and control committee chairs (who receive no payment).
- Payment is provided to key elected medical staff leadership, including Chief of Staff. MEC composition determined by MS Bylaws
- Payment is provided to key elected medical staff members, including Chief of Staff. Medical Staff Bylaws provide that all clinical department chairs are members of MEC.
- Recommended by Chair; approved by Board of Directors
- Shareholder (partner) physician
- The Chair is a physician appointed by Board of Directors (BOD). Voting members are appointed for two-year terms by the BOD based on the recommendations of the Peer Review Committee Chair. A voting member may be reappointed by the BOD. Physicians invol
- The MEC is composed of the elected Officers and also the department Chiefs, elected or appointed by the various specialties.
- Virtue of office / position
- Members are elected or appointed as per Medical Staff Bylaws
- The term “Peer Review Body” is defined in Business and Professions Code Section 805 as the Medical Executive Committee. Members of the Medical Executive Committee are largely elected or appointed. However, if Lumetra is using the term “Peer Review Body” more broadly to include any committees which conduct peer review, them members are recruited based largely on interest, willingness to serve and expertise, but sometimes the organization must offer payment in order to secure physicians willing to spend time doing peer review

Is committee composition determined by any of the following: Comp_Other, NPS_Comp_Other

- All active staff
- All dept representation
- Balance of primary care and specialists in along with willingness to serve and experience
- Bylaws
- Department Chiefs and 2 additional physician members
- Determined by hospital bylaws
- Four external physicians, two physicians (including the Chair) from the Health Plan
- Hospital administration (non-voting), nurse administration (non-voting)
- No specific percentage, but try to balance the representation
- Physician representatives of all medical staff departments and the VP of Medical Affairs, plus non-physician members from nursing, QI, administration.

- Representative of each of the Departmental peer review committees, chairs of hospital quality subcommittees and representatives of nursing, pharmacy, members services, med legal, risk and quality functions make up the membership.
- Representatives from each section and one member at large (pathology).
- Specified (by title) in Medical Staff bylaws
- The composition is outlined in the medical staff bylaws to include the chiefs of specified departments and the chairs of specified major committees as well as the President and Secretary of the Medical Staff, elected every two years
- We are 100% social workers
- All departments represented
- As assigned by Department Chair
- As designated by the Bylaws, Officers of the Medical Staff, chairs of clinical departments, immediate past president, CEO, Medical Director, CNO, Dept Anes., ER, Rad, Path and Chair of Credentials Comm.
- As dictated by the bylaws; Various Chairs of medical staff committees including medical staff officers.
- At the MEC level each Dept. elects one representative to the MEC except for Family Practice, Medicine, and Surgery that have two representatives. Each Dept. has a peer review process/committee and each Dept. is set up differently. Example Surgery
- Broad spectrum of specialties and experience
- Bylaws
- Composition is defined in the By-laws and each department has one elected representative with the exception of Medicine, Family Practice, and Surgery who each have two representatives.
- Composition is determined by the Bylaws.
- Composition is determined by the Medical Staff Bylaws.
- Composition of the committee is determined by the Bylaws.
- Composition of the committee is determined by the Medical Staff Bylaws.
- Composition of the committee is determined by the MS Bylaws
- Composition of the MEC is determined according to the Medical Staff Bylaws.
- Current Dept. Chiefs, Medical Staff Officers and 2 Medical Staff members at large.
- Department chairs
- Department peer review committees are comprised of representatives of all the sections in that department. Usually the section chiefs sit on the Department Committee.
- Department representatives
- Dept chairs or designee
- Each medical staff department has a peer review body represented by almost all of the department medical staff members.
- Each medical staff specialty within a department is represented on the department's committee.
- Interest and experience in serving on Peer Review Committee.
- Medical Staff Bylaws
- MS Bylaws determine committee makeup
- OB-Gyn, Pediatrics, Surgery, IM (cardiology), Family Practice. Medical Directors and RN's represent the Health Plan.
- Our credentialing committee is appointed by the Medical Director and the composition is primarily generalist with at least one specialist.
- Our medical staff numbers are small. We have at least one representative of specialty and generalist for the population served
- Per Medical Staff Bylaws: election/appointment
- Representation by all specialties
- Representation by all specialties
- Representation from each site of care
- Representation of all departments, Nursing and Hospital Administration; MEC composition outlined in the Medical Staff Bylaws

- Representation of each of the 5 major departments that report to the Medical Executive Committee.
- Representatives of the six medical staff departments
- Staff and the CEO.
- The committee composition includes board certified physicians contracted with a Brown & Toland representing primary care and specialty disciplines and at least one (1) member of the Board of Directors. The CMO provides oversight to the peer review
- Department elected leadership and members as specified in the Medical Staff Bylaws

What is the usual term for each member who serves on the peer review body? Term_Other

- As long as on staff
- As long as active staff
- At least 1 year
- Determined by tenure in designated position
- Fill position based on their position such as hospital executive director
- No specific term limit
- One year, usually renewed
- Usually one year but 75-80% are asked to continue longer
- Usually one year terms for most departments but multiple terms not uncommon and some departments have rotational participation
- Note can serve 2 terms totaling 4 years

Indicate reasons for non-participation. NP_Other, NPS_NP_Other

- Leaving the area
- No specific term length at this time
- Refused to agree to confidentiality statement
- Schedule conflict
- This question has no answer
- 2 year appointment none needed
- A surgical review committee and a medical review committee pre-screen all peer review cases prior to MEC. Staff members occasionally refuse to serve on those committees for all the reasons mentioned above.
- Conflicts with other medical staff responsibilities.
- Determine by Executive Medical Director and Chief of Staff
- Determined by Medical Director and Chief of Staff, I am not aware
- Do not know of any who refused to not participate
- Don't know
- I don't know the answer to this question
- If members are asked, they participate.
- MEC members change only every two years as dictated by the bylaws.
- None
- Off site practice
- Outside time constraints
- Patient Care Needs
- Question is unclear as written.
- Unknown
- Election by department
- Lack of experience

If applicable, indicate the reason(s) for the unanticipated member changes. Change_Other, NPS_Change_Other

- Acute hospital closed
- Change in departmental chief led to change in departmental quality chair

- Distance was excessive
- Illness
- NA
- New ER group
- Resignation from position
- See above
- Surgery schedule interference with meeting time and dates
- Too busy in practice
- Change in practices.
- Chief of Staff became Chief Medical Officer
- Illness
- Medical Leave of Absence
- Meeting interfered with surgery schedule.
- Members resigned from Staff
- n/a
- No longer contracted with health plan. In other words, no longer met criteria to participate
- None
- Physician practice no longer allowed participation.
- Question is unclear as written.
- Removed from Committee by Chief of Department as physician failed to follow Confidentiality Requirements
- Staff changes; left medical group membership
- Surgery scheduled interfered with meeting time/dates.
- The member became the Chair of another committee.
- Was removed regarding confidentiality of information.

Indicate responsibilities of the peer review body Res_Other_Com, NPS_Res_Other_Com

- 805,823.5,oversight hearing would fall under this bodies responsibilities, but we have not had to address any of these issues
- Above answers refer to the Medical Executive Committee as ultimately overseeing peer review
- All items not checked are either pursued by the chiefs of service, a med exec committee or our focused review committee that involves Med Director, CEO, C&P chair etc.
- Quality Improvement activities
- Review and oversight of all departmental quality programs
- The list of choices for this question is unclear. For example, what does Lumetra mean by "a physician's practice pattern" or "series of complaints/events about physician"? Does Lumetra mean to ask whether the peer review body reviews these things????
- The list of choices is unclear regarding definition of physician practice pattern, etc.
- We do not review physicians' performance. We respond to inquiries from our members about ethical issues in their areas of practice AND respond to concerns raised by clients
- Also track/monitor quality of care issues for other healthcare professionals and facilities (not only physicians)
- Approve new providers Approve providers going through recredentialing (every 3 years) Approve policies & procedures annually Review malpractice issues & any medical board actions
- Credentialing and recredentialing
- Initial and re-credentialing for participation, monitoring of medical board sanctions, CMS Reports, Maintenance of medical staff participation and status. Licensing and Malpractice coverage review.
- Initial screenings are handled by a lower committee/department first and referred to MEC as appropriate.
- MEC acts on peer review issues referred by the Departments or on issues referred to by others. Indicator screening measures are initiated by Performance Improvement and sent to Departments as indicated. Patterns/trends or significant events are sent to
- MEC does not do the root cause analysis of Sentinel events. It reviews results.

- Multiple responsibilities as defined by the bylaws
- Oversight of the peer review process and compliance with organizational standards and policy that guide peer review.
- Please note that initial screening and review may be handled by a department or committee and then referred to MEC, if necessary.
- Please note that initial screenings and review may be handled by a department or other Clinical Practice committee and then referred to MEC, if necessary.
- Please note that initial screenings and review may be handled by a department or other committee and then referred to the Medical Executive Committee, if necessary.
- Please note that initial screenings are usually handled by a lower committee first and referred to MEC if necessary.
- Please note that the initial screenings and review may be handled by a department or other committee and then referred to the Medical Executive Committee if necessary.
- Please note: usually initial screenings are handled by a lower committee first and referred to MEC if necessary.
- Poorly worded questions-MEC convenes hearings. List of choices unclear-practice pattern means what?
- Question is unclear as written.
- Report suspension recommendations to C&P
- The final decision for 805 is with MEC
- The list of choices for this question is unclear. For example, what does Lumetra mean by "a physician's practice pattern" or "series of complaints/events about physician"? Does Lumetra mean to ask whether the peer review body reviews these things???
- The Peer Review Committee is responsible for the overall monitoring and evaluation of individual physician and provider appropriateness and effectiveness of delivering medical care and service.

Other circumstances or criteria for which an 805 or 821.5 report WOULD BE CONSIDERED:
A_B_Other_Com, NPS_A_B_Other_Com

- Almost none of the items in this list are criteria for 805 or 821.5 reports. 805 and 821.5 reports are considered/filed only under the circumstances identified in Bus and Professions Code Sections 805 and 821.5.
- None
- None of this applies to us at all
- Our PR committee is an educational/ quality improvement committee. 805, 821.5 issues are evaluated by the chief medical officer/ management
- Reports are considered/filed under the circumstances identified in business & professions code sections 805 & 821.5
- Suspension more than 30 days/calendar year
- Though the next level _could_ review anything for any reason at our institution, in general the criterion for advancing to the next level of peer review is for any of the above (primary) triggers to be found to have enough merit for the peer review body
- Whenever a pattern of adverse peer review findings or a rate of complaints exceeding predetermined threshold is exceeded, malpractice experience exceeding threshold or referral by certain hospital or medical staff leaders a review committee is convened to
- 805 are initiated when the criteria of the law is met for example application for privileges is denied for medical disciplinary cause or reason.
- A. BTMG will file and 805 Report to the MBOC and/or adverse action report with the NPDB if an applicant to BTMG, or a BTMG contracted provider does any of the following after notice of either an investigation, or the impending denial or rejection of his
- All of the checked criteria above could trigger initial screening, based on the findings would lead to first level peer review if significant findings (i.e. severity and outcome of incident) would be elevated to higher level for a formal investigation.

- All of the events checked would result in investigation and review. If screening indicates a potentially reportable event the case would be referred to MEC for investigation and reporting if indicated. A patient complaint may or may not warrant 805 or 8
- An 805 report is filed when the Peer Review body takes an adverse action as defined in section 805.
- Any of the above-listed events could lead to a review and investigation that could result in an 805 report depending upon the evidence before the committee and its findings.
- Any of the above events could lead to a review and investigation that could result in an 805 report, depending on the evidence before the committee and its findings.
- Any of the above events could lead to a review and investigation that could result in an 805/821.5 report, depending upon the evidence before the committee and its findings.
- Any of the above listed events could lead to a review and investigation that could result in an 805 report depending upon the evidence before the committee and its findings.
- Any of the above listed events could lead to a review and investigation that could result in an 805 report depending upon the evidence before the committee and its findings.
- Any of the above listed events could lead to review and investigation that could result in an 805 report depending upon the evidence before the committee and its findings.
- Any one of the above criteria could trigger a reportable peer review action or a reportable peer review investigation
- Any one of the items above could trigger a reportable peer review action or a reportable peer review investigation. None of the criteria drive the decision about whether a report is required.
- Any one of these things could trigger a reportable peer review action or a reportable peer review investigation.
- B - outside confirmed reports challenging MDs mental and/or physical condition;
- I would always report in accordance with the Business and Professions Code.
- In any of the above instances, if related to a physician, could potentially result in reporting.
- Non-cooperation with the Ethics Committee or resignation/membership lapse during the course of investigation of the member by the Ethics Committee
- None
- None of these items in this list are criteria for 805 or 812.5.
- Question is unclear as written. These reports are filed as required by Business and Professions Code sections 805 and 821.5.
- Question is vague and impossible to answer
- We have never filed an 805 report although our plan would allow us to do so.
- None of the listed criteria drive the decision about whether a report is required. As with one of the prior questions, any one of the listed items might result in a peer review action that is reportable under 805 or might trigger an investigation if there is a suspected impairment which would be reportable under 821.5 – but the criteria listed do not determine whether a case is reported under either statute.

Other position of the person, committee, or mechanism that determines whether to refer an issue to a secondary or higher review body in the organization. Refer_Other, NPS_Refer_Other_Com

- Advice by medical director.
- After discussion by Department head, the physician's case would be reviewed by the Medical Executive committee, and a determination of action would be under taken. This includes, formal reprimand, personal interview, and suspension of privileges.
- Chief Medical Officer, who is also the Chair for Peer Review
- Chief of Staff or CEO
- Consensus
- I can tell you what we do for the social work profession, but that doesn't appear to be the point of this survey
- Medical Director
- QM Committee

- The place that a problem would go from QI is Credentialing Committee; where by organizational mandate an MD with 3 serious levels are sent.
- Any of the Medical Staff Committees can refer to the higher review body. I am not sure what you meant by the chair of initial screening committee. We do not have a Professional Affairs Committee.
- Any peer reviewer or committee established under the medical staff has the ability to refer an issue to a higher body under the bylaws.
- By action of the committee, in keeping with the specific procedures expressed in the association's ethical standards.
- By majority vote of the Med Exec Committee
- Chief
- Chief and Vice Chief of Staff
- CMO, Peer Review Committee Chair, Peer Review Committee Members (majority vote), Legal Dept.
- Could refer to MEC.
- Executive Medical Director
- Issues may be referred to a higher review body from both clinical and administrative levels. The Medical Staff Bylaws allow some flexibility so as to allow appropriate attention for matters of concern, regardless of the source.
- Peer Review Committee
- Performance Improvement Medical Director
- Please note issues may be referred to a higher review body from both clinical and administrative levels. The Bylaws provide some flexibility so as to allow appropriate attention for matters of concerns regardless of the sources.
- Please note that issues may be referred to a higher review body from both clinical and administrative levels. The Medical Staff Bylaws provide some flexibility so as to allow appropriate attention for matters of concerns regardless of source.
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- Please note: issues may be referred to a higher review body from both clinical and administrative levels. The Bylaws provide some flexibility so as to allow appropriate attention for matters of concerns regardless of the sources.
- Quality & Patient Safety Department
- Quality and Service triggers require consideration of a focused practice review. Requests for a Focused practice review may also come from Hospital Administrator, Chief of Staff, Chief of Quality, Medical Legal Chief, Department Chief and Medical Executive
- Quality Committee
- Question is unclear as written. Reports are considered and filed according to BPC 805 and 821.5
- The Credentialing Chair and Medical Director together would bring a serious concern to the attention of the Board of Directors if they felt they needed a higher review body.

Other criteria used to determine whether a case is REPORTED (805 or 821.5) to the Medical Board of California (MBC): Report_Other_Com, NPS_Report_Other_Com

- 805 are initiated when legal criteria are met for such report
- 805 report only done after action is taken, or resignation in middle of investigation, etc as per the law
- All of the above may apply. The decision to take action is not the responsibility of our Peer Review Committee
- Almost none of the items in this list are criteria for 805 or 821.5 reports. 805 and 821.5 reports are considered/filed only under the circumstances identified in Bus and Prof Code Sections 805 and 821.5.
- Complaints or deficits in care that are either very severe, repetitive, or refractory, or which require change in privileges or activity.
- Could include any of the above if, after investigation, a significant problem is identified
- Majority vote of executive committee
- MEC
- N/A we don't refer to the California Medical Board
- Only if the incident of concern was not already or in the process of being reported by one of our contracted entities. Since we do not directly contract with physicians, there are entities that hold the direct contract with the physician who has greater
- Reports are considered/filed only under the circumstances identified in business & professions code sections 805 & 821.5
- This determination is made by the Chief of Staff and CEO on the advice of counsel. I am not directly involved in the decision.
- This question has no answer. There are no 'criteria', but rather a specific legal standard (ie: it's in the law what to report). We get legal counsel on any case which appears to be anywhere NEAR these requirements, as to whether a report needs to be g
- We report what the law & regulation require us to report. Medical staff administrative staff and attorneys advise us on that as needed.
- When the law requires it. Is this a trick question??
- 805 are initiated when the criteria of the law is met for example application for privileges is denied for medical disciplinary cause or reason, summary suspension, etc.
- After determination by Peer Review Committee
- All of the above could be "triggers" and in combination lead to 805 reporting
- All of the above unchecked items would result in initial peer review screening. If warranted, the incidents would be peer reviewed at a dept. level. Depending on severity/outcome the incident/incidents could be referred to MEC for investigation and ac
- Almost none of the items in this list are criteria for 805 or 821.5 reports. 805 and 821.5 reports are considered/filed only under the circumstances identified in Business and Prof Code sections 805 and 821.5.
- Any one of the listed items might result in a peer review action that is reportable or might trigger an investigation if there is a suspected impairment which would e reportable but the criteria listed does not determine whether a case is reported under e
- BTMG will file and 805 Report to the MBOC and/or adverse action report with the NPDB if an applicant to BTMG, or a BTMG contracted provider does any of the following after notice of either an investigation, or the impending denial or rejection of his or
- Confirmation from an outside neuropsychiatric MD of a physician's disabling physical and/or mental condition.
- Could be any and/or all of the above
- Criteria according to legislated 805 or 821.5 criteria.
- Decision by the Medical Executive Committee
- Final actions restricting, limiting or terminating privileges or membership for medical disciplinary cause or reasons
- For non-cooperation with the Ethics Committee or where there is resignation/membership lapse during the course of investigation of the member by the Ethics Committee

- If it meets the requirements mandated to be reported as outlined in B&P Code Section 805
- It is a legal determination.
- MED recommendation to the Board of Trustees after appropriate investigation.
- Mostly those issues that are outlined by Section 805.
- Other items listed not criteria - see the B&B code 805 for appropriate criteria for reporting. We comply.
- Question is unclear as written. Criteria used according to BPC 805 and 821.5
- Reporting to Medical Board is made in accordance with the obligations/requirements set forth in Section 805 and 821.5, including resignation or leave of absences during an investigation for termination of privileges.
- Reporting to the Medical Board is made in accordance with the obligations/requirements set forth in Sections 805 and 821.5
- Reporting to the Medical Board is made in accordance with the obligations/requirements set forth in Sections 805 and 821.5.
- Reports to the MBC are made in accordance with the obligations/requirements set forth in Sections 805 and 821.5, including resignation or leave of absence during an investigation.
- Resignation or leave of absence during investigation; termination of privileges. Reporting to the Medical Board is made in accordance with the obligations/ requirements set forth in Sections 805. and 821.5
- The criteria listed do not determine whether a case is reported under 805 or 821.5.
- We have never issued an 805 report.
- We have never reported a physician to the medical board
- We use the guidelines provided by NCQA CR 10
- This is a legal determination made by MEC admin & legal counsel.
- None of these criteria drive the decision. Any one of these listed items might result in peer review action that is reportable under 805 or might trigger an investigation if there is an impairement that would be reportable under 821.5 but the criteria listed do not determine whether a case is reported

Other person, committee, or mechanism that determines whether an issue (805 or 821.5) is reported to the Medical Board of California (MBC): MBC_Report_Other_Com, NPS_MBC_Report_Other_Com

- A decision is made by the voting members of the Medical Executive Committee
- An 805 or 821.5 report is filed after we determine whether an action of investigation falls within the mandatory reporting categories detailed in Bus and Prof Code sections 805 and 821.5.
- Consultation with legal counsel
- Hospital executive committee
- Legal counsel with specific expertise in this area.
- MEC
- MEC in consultation with attorney
- Medical Director
- Medical Executive Committee
- N/a see above
- None of these; it is a MEC decision, with legal counsel as above and in cooperation with administration.
- Reports are considered/filed only under the circumstances identified in business & professions code sections 805 & 821.5
- See previous responses
- This determination is made by the Chief of Staff and CEO on the advice of counsel.
- All actions required to be reported by statute are made consistent with legal advice provided to the MEC.
- All actions required to be reported by statute are made consistent with legal advice provided to the MEC

- All actions required to be reported by statute are made consistent with legal advice provided to the MEC.
- All actions required to be reported by statute are made consistent with legal advice provided to the Medical Executive Committee.
- All final actions required to be reported by statute are made consistent with legal advice to the committee.
- Attorney
- Board of Directors
- Board of the medical group
- Board of Trustees
- But Board of Trustee approval is the final requirement before reporting.
- Chief of Staff or CEO
- Chief of Staff, Hospital Administrator
- Executive and Quality Committee of the Board
- Executive Committee
- Executive Committee of the Professional Staff
- For non-cooperation with the Ethics Committee or the resignation/membership lapse during the course of investigation of the member by the Ethics Committee
- Hospital Administrator
- It is a legal determination.
- Legal Counsel
- Legal Dept.
- Majority vote of the Med Exec Committee
- Majority vote of the Medical Executive Committee
- MEC
- MEC. Reports are filed in they fall within the mandatory reporting category.
- Medical Director
- Medical Executive Committee
- Medical Executive Committee in consultation with legal counsel.
- Medical Executive Committee or Bylaws Designee
- Question is unclear as written. The mechanism used is as per BPC 805 and 821.5 reporting requirements.
- Reportability is based on 805 guidelines.
- The determination as to whether something is reported is a legal determination and that is made by the Medical Executive Committee and Hospital Administration
- The determination as to whether something is reported is made by the Medical Executive Committee and Hospital Administrator, with the advice of legal counsel.
- the Medical Executive Committee make the final decision regarding an 805. The department requesting the 805 presents the case and the full MEC votes regarding the recommendations and decision to issue and 805.
- Upon the advise of Medical Staff legal after consideration by the Medical Executive Committee
- We have never reported an issue to the MBC
- The determination is a legal issue made by MEC and hospital and with the advice of legal counsel.
- The determination as to whether something is reported is a legal determination and is made by the Medical Executive Committee and Hospital Administration, with the advice of legal counsel.

After a reportable event (805 or 821.5), the organization's designated peer review officer must submit a report to the relevant agency within Other Rpt_Time_Other_Com, NPS_Rpt_Time_Other_Com

- Consult with legal counsel
- Depends on the nature of the event
- Don’t know
- Don’t know

- Don't know
- I am not directly involved in reporting.
- I would verify with QI staff though I believe up to 30 days
- NA
- This is not a matter handled by QI in our organization.
- We follow the law
- I would have to look that information up
- In accordance with the Medical Board of Ca regulations
- N/A
- Not aware
- Per regulation
- Within 15 days of the effective date of a decision by the BOD to terminate, revoke or suspend the contracted practitioner's membership or participation.

After the licentiate has satisfied the terms of a disciplinary action, a supplemental report is made to the relevant agency within Other : Sup_Rpt_Other_Com, NPS_Sup_Rpt_Other_Com

- As above
- Consult with legal counsel
- Don’t know
- Don't know
- I am not directly involved in reporting.
- I would verify with QI staff though I believe 90 days
- NA
- POP QUIZ
- This is not a matter handled by QI in our organization.
- 1-60
- Disciplinary actions are confidential and not reported unless the member is non-cooperative with the ethics committee or resigns or permits his/her membership to lapse during the course of the investigation.
- I would have to look that information up
- In accordance with the relevant agency guidelines
- N/A
- Not applicable
- Not aware
- Not sure
- Per regulation
- After licentiate has satisfied the terms of discipline
- Per legal counsel 1 to 60 days is the correct answer.

After initiating a formal investigation of a potential 821.5 event, the organization's designated peer review officer must submit a report within: PRO_Time_Other_Com, NPS_PRO_Time_Other_Com

- ?
- As above
- Consult with legal counsel
- Don’t know
- Don't know
- I am not directly involved in reporting.
- I would verify but believe 15 days
- Not sure, would have to check our policy
- POP QUIZ!
- The term "821.5 event" is unclear.
- The tern 821.5 event is unclear

- This is not a matter handled by QI in our organization.
- Varies
- 1-30 days
- Don’t know
- Don't know
- I do not know; would need to check policy
- I would have to look that information up
- In accordance with the relevant agency guidelines
- N/A
- N/a This section applies to physicians. There are no physicians in this association.
- No report until completion of investigation and final action.
- Not applicable.
- Not aware
- Not known
- Per regulation
- Term 821.5 is unclear.
- Unclear as to "potential" 821.5 event

Upon receipt of an 821.5 report, the MBC diversion program administrator shall contact the reporting peer review body within: Other MBC_Time_Other_Com, NPS_MBC_Other_Com

- ?
- Consult with legal counsel
- Don’t know
- Don't know
- Don't Know
- Don’t know we have never filed one
- I am not directly involved in reporting.
- I would verify but believe 90 days
- The MBC has disbanded the diversion program
- The MBC has disbanded the Diversion Program.
- This is not a matter handled by QI in our organization.
- Unknown
- Dependent on MBC diversion program agent
- Don’t know
- Don't Know
- I do not know; would need to check policy
- I would have to look that information up
- In accordance with the relevant agency guidelines
- N/A
- N/a This section applies to physicians. There are no physicians in this association.
- No diversion program exist with MBC
- Not applicable.
- Not aware
- Not known
- Not sure
- Per regulation
- The MBC disbanded the Diversion Program.
- This program is no longer available
- Unknown
- No longer applicable – diversion program closed.

Other criteria used for filing/not filing an 805 report Rsn_805_Other_Com, NPS_Rsn_805_Other_Com, PR_Rsn_805_Other_Com, RP_Rsn_805_Other_Com, AP_Rsn_805_Other_Com, APRB_Rsn_805_Other_Com

- Credentials Committee is tasked with these matters in our organization.
- Denial or restriction of participation by the health plan for quality of care reasons
- Don't know for sure about some of these.
- I am not directly involved in reporting.
- None of this applies to us
- OUR Peer Review Committee is not responsible for filing a 805 report
- Question is unclear
- Resignation from participation during an investigation
- And as may be required by statue.
- And as may be required by statute.
- And as may be required by statute.
- And as may otherwise be required by statute.
- And, as may be required by statute.
- BTMG will file and 805 Report to the MBOC and/or adverse action report with the NPDB if an applicant to BTMG, or a BTMG contracted provider does any of the following after notice of either an investigation, or the impending denial or rejection of his or
- Clarification: Item #5, "Resignation or leave of absence".... while under investigation - and as may be required by statute.
- Failure to comply with Peer Review Committee corrective action plan; failure to correct substandard practice despite corrective action plans implemented/completed.
- For non-cooperation with the Ethics Committee or where there is resignation/membership lapse during the course of investigation of the member by the Ethics Committee
- I'm not sure at this time
- I am not a part of the medical staff, and do not know
- My answer is based on a missing element that is "for medical disciplinary cause or reason."
- Not answerable the way you worded this. When answering this question how will you know its for filing or not filing?
- Per regulation
- Question is unclear. 805 reports are filed according to BPC 805 requirements.
- Resignation or leave of absence, withdraw or abandonment of application or request for renewal of privileges reported after notice of investigation based medical disciplinary cause or reason
- Resignation or loa, withdrawal or abandonment of app or request for renewal of privileges or membership that occurs after notice of an impending investigation or denial or rejection for medical disciplinary cause or reason.
- We have never reported an issue to the MBC
- When a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges or employment - "for medical disciplinary cause or reason" was not included in the answer. Also - Resignation, leave of absence or withdrawal
- 4th question wording confusing
- I am not familiar with an 805 report
- See http://www.allianceforpatientsafety.org
- Timing of diagnosis
- Above criteria do not differentiate between quality of care issues vs. administrative issues.
- Boxes 4 and 5 should be together
- Don’t know what an 805 is
- I have never heard of an 805 report
- I rely on the hospital administrative staff and non-physician quality personnel to verify and inform re all indications for filing an 805
- MBC criteria
- No idea
- Question 4 is poor question; part is incorrect and part is correct -- should be clear yes or no.

- Unknown
- Both the notice of investigation bullet and the resignation bullet are also limited by the medical disciplinary cause or reason requirement. It is also presumed in cases of summary suspension.
- I don't understand how to respond to this question since it says to indicate criteria for filing/not filing. if I check something off, how do you know if I mean it is a basis for "filing" or a basis for "not filing"? In addition, some of the answer depe
- Resignation etc, after notice of an impending investigation for medical disciplinary cause or reason
- The second bullet and the one on resignation are limited by the medical disciplinary cause or reason requirement, which is also presumed in the case of a summary suspension.
- This question makes no sense and is unanswerable.
- Okay for medical disc. cause or reason
- The filing must be a result of an action of a peer review body. The form must be signed by the chief of staff.

Other criteria used for filing an 821.5 report for a physician or surgeon POSING A THREAT TO PATIENT CARE: Rsn_821_Other_Com, NPS_Rsn_821_Other_Com

- Credentials Committee is tasked with this in our organization.
- I am not directly involved in reporting.
- N/a
- None are criteria for filing an 821.5. An 821.5 report is filed only when the medical staff has initiated a formal investigation of a physician & surgeons ability to practice medicine safely based upon information indicating the physician & surgeon may b
- None of these are criteria for filing an 821.5 report. An 821.5 report is filed only when the medical staff has initiated a formal investigation of a physician and surgeon's ability to practice medicine safely based upon information indicating that the
- Any one of those items would trigger an 821.5 if the Medical Executive Committee convened a formal investigation.
- Any one of those items would trigger an 821.5 IF the Medical Executive Committee convened a formal investigation.
- Depends following investigation
- I'm not sure
- I am not a part of the medical staff and do not know.
- N/A
- N/a There are no physicians in this association
- Not applicable.
- Reportable only if the MEC convened a formal investigation.
- Unclear question. A formal investigative process must first occur before such a filing occurs.
- An 821.5 only required when MEC commences a formal investigation because of suspected impairment.
- Most often these matters are handled by well being comm.. and 821.5 reports are not filed. An 821.5 report is only required when the MEC convenes a formal investigation into a MD.It is the convening of the investigation that determines whether an 821.5 report is filed, not the existence of a physical, mental, or chemical problem.

Other resources available to assist you in your determination for filing: Resource_Other_Com

- Credentials committee is tasked with these matters in our organization.
- Experts within the organization
- Hospital counsel
- Hospital legal counsel.
- In-house experts/attorneys
- In house counsel
- Legal consultation
- Legal counsel

- Legal counsel
- Legal Counsel within the organization.
- Legal counsel, probably CMA
- Legal Staff consultation
- N/a
- Outside legal counsel.
- Would have to check policy

Please list the reasons of the highest three costs. Cost_reason, PR_Cost_Reason

- Do not know
- Don't know
- I am not directly involved in reporting and cannot estimate the cost.
- I don't have any way to answer that question. I answered the question only to move forward in the survey.
- I have no clear idea. A guess.
- I no 805 or 821.5 reported
- Lawyers, lawyers, lawyers
- Legal fees for investigating allegations staff time for preparation of cases. Outside reviewers for opinions
- N/a
- No 805 reported, 0 dollar amount.
- Personnel costs, legal fees, professional time spent (all this is an estimate)
- Preparation & attendance salaries
- Staff time reviewing cases and complaints- all quality issues are "potential" 805 reports as above.
- No costs incurred
- See http://www.allianceforpatientsafety.org
- This MD has not had any 805 or 821.5 issues.
- Attorney's cost
- However, in hospital peer review >$750,000
- Attorney fee, reviewer fee, copying of records
- Legal costs, lost income
- Attorney fees
- Lost earnings from shifts not worked.
- Legal fees, Time lost from work, loss of revenue
- Attorney, Documents, time lost work

If you have experienced or are aware of 805 reporting used for reasons other than intended (ensuring patient safety), please list the reasons. Political_Rsn, NPS_Political_Rsn, PR_Political_Rsn, RP_Political_Rsn, AP_Political_Rsn, APRB_Political_Rsn

- No
- NO
- What is an 809 hearing?
- 805 reporting is not used for "political" reasons. The checks and balances in place make that extremely unlikely.
- 805 reporting is not used for "political" reasons. The checks and balances in place make this extremely unlikely.
- 805 Reports are not used for "political" reasons. The checks and balances in place make it extremely unlikely.
- N/a
- N/A
- Please note that 805 reporting is not used for "political" reasons. The checks and balances in place make it extremely unlikely.

- Please note, 805 reporting is not used for "political" reasons. The checks and balances in place make it extremely unlikely to do so.
- Please note: 805 reporting is not used for "political" reasons. The checks and balances in place make it extremely unlikely.
- Please note: 805 reporting is not used for "political" reasons. The checks and balances in place make it extremely unlikely.
- Please note: 805 reporting is not used for "political" reasons. The checks and balances in place make it extremely unlikely.
- No 805 in my case, but lesser peer review used to manipulate me into agreeing to a call-sharing plan to which I objected.
- See http://www.allianceforpatientsafety.org
- I am not aware of any 805 filings since I have been a member
- I do not know what this is
- No
- Have never had this occur in 25+ years of doing this work.
- More than unlikely have never had this occur in 25+ years of representing medical staffs.
- This comment does not relate to the question above. Instead it relates to the two previous questions to which I was "forced" to respond. Specifically, I was forced to answer questions about number of hours spent on various "805" and "821.5" related act
- This comment does not relate to the question above. Instead it relates to the two previous questions to which I was "forced" to respond. Specifically, I was forced to answer questions about number of hours spent on various "805" and "821.5" related acti
- This hospital Dr. XXX uses peer review to bully to punish his competitor
- Knee jerk reaction to bad outcomes when neither action nor inaction by MD the cause of the bad outcome.
- For leverage to try to get me to settle “out of court”. The hospital has a very poor case and no evidence except hearsay. They want to get rid of me and I refuse to back down as I’ve done nothing wrong.
- Skewed exam results
- Oust me from the department
- Control practices, reduce competition for desirable shifts, discredit others
- Prompting medical board investigation, creating mental stress. Preventing my return to the job.
- People on committees are mostly incompetent or retired physicians who don’t have much else to do.
- No justification on basis of (cannot read). Prologed responses more than 1.5 years and still no formal response.

List your recommendations for changes to the 805 reporting forms to make them more user-friendly and clear: Form_Changes, NPS_Form_Changes

- Give more examples
- I am not directly involved in reporting.
- Never had to use reporting forms
- Never had to use reporting forms.
- Never used one...
- No experience.
- None
- Again, we have never reported an 805 to the MBC so it's difficult to answer these questions.
- Complete the form electronically.
- Electronic/on-line option.
- I do not handle the 805 reports, so I do not know what the level of difficulty for using the 805 forms would be.
- I have not used MBC's current 805 reporting forms
- No experience with the 805 reporting forms.
- PDF fill in with electronic signature and submittal.

- Please note: There are no physicians in this association. 805 reports are not submitted by the association to the Medical Board, they are submitted to the Board of Behavioral Sciences.
- Types of actions do not always fit a specific circumstance.

Please include any problems you have experienced with the 809 procedure. Problems_809, NPS_Problems_809, PR_Problems_809, RP_Problems_809, AP_Problems_809, APRB_Problems

- After 7 months the charges were still being brought with no end in site of more charges to come
- Have not been involved with process
- Have not been involved with the process.
- I have no idea.
- I have not been directly involved in and 809 hearing and none have occurred in my organization in the past year.
- Process may take a long time because of availability of parties involved.
- We are not involved with 809 hearings
- We have not had any hearing in the past year, hence no problems
- Have not participated in an 809 hearing
- I am not familiar with an 809 hearing.
- I am not familiar with the process
- I don't know
- Never involved in an 809
- No experience in this area
- Not outlined in our own bylaws, as it is a California Business and Professions Code requirement.
- Unable to answer...never been involved in an 809 hearing.
- I am not familiar with 809 hearings
- N/a--CMB review was case initiated by patient's family RRH peer review never got to QI committee
- See http://www.allianceforpatientsafety.org
- The hospital imposes and pays the hearing officer. The same hearing officer decides who sits on the panel, what evidence is allowed. He writes the decision and the panel just rubber stamp. Arbitrators will be much better option. Hospitals never a
- Don't know.
- I've never had to participate in an 809 hearing, but I'd surmise that items 1-5 above are applicable
- I am not familiar with the requirements since there has not been one involving my facility
- N/A This is a problem with your survey
- No 809's during the 18 months I have been involved in peer review at this hospital-don't know answers
- No experience with 809 hearings
- Not sure
- Unknown
- Generally the hearing is postponed by mutual agreement beyond the 60-day limit due to the calendars of those involved.
- It is often difficult to start the hearing within 60 days as it is extremely difficult to find dates that work for the many people (largely physicians) involved. In addition, physicians are increasingly unwilling to participate in the time consuming hear
- The procedure is too cumbersome and can be used to impose significant delays in resolution of the underlying issue. The process should have a statutory time frame for completing the 809 process, such as 90 days or 120 days after initiation. The "unavai
- These are some of the B and P Code Section 809 requirements. Others include notice to the physician, a written decision, etc. See the statute for a full list.
- These are some of the rights articulated in B and P Code Section 809--there are others such as notice, right to a written decision, etc. For a full list refer to the statute.
- 805 has been filed and will likely be dropped once the hospital exonerates me.

- Initial review unfair. They ignored all the “hard evidence” (charts, etc) and relied on hearsay. Hearing just started, will likely be fair.
- Denied right to hearing within 60 days “evidence” (charts) by hospital was withheld for over 90 days. Actual charges not provided until 67 days. Hearing began 7 plus months after they received our report.
- Outcome decided prior to any hearing.
- Biased, bad faith peer review. My complaints were never heard.
- I do not know what this is.
- I requested hearing. The governing body totally ignored my request.
- Never experienced it.
- Never offered to me.

For 'other' obstacles, specify and indicate type of reporting (805 or 821.5): Other_Obstacle_Com, NPS_Other_Obstacle, APRB_Other_Obstacle, AP_Other_Obstacle

- Have not reported 805 or 821.5
- Have not reported an 805 or 821.5
- Have not reported and 805 or 821.5
- More restrictive interpretation when declaring "medical disciplinary cause or reason" due to potential for 809 hearing.
- New modifications to "Whistle-blower" STATUTES TO EXTEND PROTEDTION TO THE MEDICAL STAFF
- We don't make these reports
- Dissolution of the MBC's Diversion Program
- Medical Staff Bylaws and MBC statute describe reporting obligations after due process completed.
- No experience.
- 805 reporting is not taken lightly both because it is serious and is accompanied by burdensome hearing rights. But the staffs I represent put the interests of patients and assuring that qualified professionals serve on their staffs first.
- Again, I do not see these are issues that play a part in medical staff decision-making.
- The peer review process is a "guild" process and fellow guild members are reluctant to take action against each other. The public safety should be better served by revamping the entire statutory process to have physician competence in an 805 situation i

For 'other' recommendations to avoid the above obstacles:, specify. Obs_Other_PR_Com, NPS_Obs_Other_PR_Com, APRB_Obs_Other_PR_Com, AP_Obs_Other_PR_Com, RP_Obs_Other_Com

- Have not had to report a provider
- Institute a preliminary hearing body to determine whether the party that bears burden of proof has sufficient evidence to potentially resolve reasonable doubts during a 809 hearing prior to assembling an 809 hearing (e.g. standards for evidence sufficient
- Legal protections for reporters
- We don't make these reports
- A Multidisciplinary Peer Review Body vs. departmental peer review.
- Facility can and does overcome these obstacles
- Fair hearing
- I do not participate in the process
- No recommendations/no experience.
- Not applicable.
- Peer review should become more focused on educational opportunities versus being punitive in nature.
- Typically our facility overcomes these obstacles
- Viable alternative to the MBC Diversion Program

- I am using this space only to note that for questions two and three; I was required to select an answer in order to continue with the survey. However, because of the inaccurate and unclear phraseology of both of the questions, my answers should be disre
- I do not know if that is a realistic solution, but the current system is cumbersome and it is getting increasingly difficult to get physicians to agree to participate in peer review and discipline of their colleagues.
- I represent over 50 staffs in this State. They take peer review seriously and are in the best position to evaluate the members of their medical staffs.
- Medical staffs that I represent (50+) take their obligations seriously and try to act in the best interests of patient care.
- The 805 process doesn't work because physicians can't do a good job of holding each other accountable. There are too many relationships that interfere with the process.
- The peer review process is a "guild" process and fellow guild members are reluctant to take action against each other. The public safety should be better served by revamping the entire statutory process to have physician competence in an 805 situation I
- I have not had any concerns about the peer review we have done
- I think, in general, the system works except for special circumstances where procedures are not done that often in the community or the expertise is limited in a specialty. Please see comments below.
- Not familiar with procedure.
- Unable to understand the question to comment
- What "obstacles". The question is ambiguous. If this relates to question 8 there are no obstacles with an arbitrator. If this relates to peer review in general, we ask for review "outside the geographic area to maintain impartiality.

For 'other' recommendations to improve the current peer review process:, specify:
Rec_Other_Com, NPS_Rec_Other_Com, PR_Rec_Other_Com, RP_Rec_Other_Com, APRB_Rec_Other_Com, AP_Rec_Other_Com

- ALLOW A LONGER PERIOD OF RESTRICTION BEFORE REQUIRING NOTIFICATION OF THE MBC. IF THERE IS A CONCERN ABOUT A PHYSICIAN, 30 DAYS IS NOT SUFFICIENT TIME TO DETERMINE IF THERE IS A PROBLEM. 60-90 DAYS IS MORE REALISTIC. tHE VERY SHORT TIME FRAME IN THE RE
- Improve communication to physicians undergoing peer review Updating screening tools Considering changing our committee structure to have one peer review body
- Make sure that the peer review documents are not discoverable by outside agencies. This is the ONLY way to make peer review most effective.
- State funded MDs, Attorney, and Administrators to review cases.
- Emphasis on objective learning versus judgment
- I do not participate in the process
- Our current peer review process works well.
- Peer review needs to be more of an evaluation of physicians practice against standards of care via ongoing performance monitoring. Behavioral issues would still need to be dealt with outside of data monitoring.
- Peer review needs to remain as a Medical Staff function.
- Regarding below question: You can't take action based on allegations alone - evaluation must be done by the appropriate specialty department. M.S. Bylaws regarding adverse recommendations must be followed. Questions are difficult to answer in the mann
- Repeal AB632.
- See http://www.allianceforpatientsafety.org
- The specialty college can be a neutral body to conduct peer review and credentialing.
- Timeliness- it is unfair to hold the sword over the head of a practitioner for 18 months! A board review is far more threatening than a lawsuit!

- Consider a network of other rural hospitals to perform peer review. We function differently than urban hospitals and our resources and needs are different. A non-affiliated peer review body that is familiar with these challenges would be ideal.
- Not having participated in such a review, I've not been aware of the pitfalls. But if there are significant claims of unfair practice, I'd favor an independent organization.
- This is not based on my work with HPSM but experience in another organization.
- This organization would be available on an "as needed" basis when our own medical staff had conflicts of interest or inadequate providers in a specialty for example. The general peer review would still take place within the institution, using the indepe
- Use the IHI Model for "triggers" which would help identify risk points in an organization. We waste to many resources focusing on case based retrospective review.
- I do not know if that is a realistic solution, but the current system is cumbersome and it is getting increasingly difficult to get physicians to agree to participate in peer review and discipline of their colleagues.
- I think that peer review should be handled the same manner that licensure issues are handled--an objective administrative hearing that is fair to both the facility and the physician. I don't think that a governmental entity is preferable over a non-gov
- Peer review is best done by medical staff physicians in the facility who best know their hospital, its standards and their staff members.
- See above comment--taking peer review out of the individual hospitals/staffs would mean those in the best position to evaluate a staff member would be precluded from doing so. This was proposed and rejected in legislation several years ago.
- Using out of area members of the JRC should be helpful.
- Eliminate need for this.
- In the case of the CDCR, central peer review has only led to blaming physicians for system failures, such as a lack of adequate and timely consultations, availability of specialist consultants, and support for the physicians in the clinics.
- Penalties imposed on hospitals for violating 809 with compensation to MD being reviewed including punitive damages minimum 3x actual damages. This is necessary because false accusations and 809 violations pose undue hardships on accused MD, so he should be entitled to an expedited hearing. Hospitals have millions of dollars to pursue MDs who have more limited financial resources to fight false charges.
- The absence of 805 reporting doesn't suggest peer review is ineffective. It suggests that the peer review process is effective and working properly because it identifies & addresses problems early on not that a practitioner can make errors. Change in proactive is conducted so that the situation doesn't become an adverse action that must be reported.
- Independent agency should discuss, review and challenge mistakes made by the peer reviewers.
- I'm not sure how to eliminate manipulation of the process. It must be objective. Transparency would help.
- I'm not sure how to eliminate manipulation of the process. It must be objective. Transparency would help.
- Specify that the majority of a peer review body must be peers who work at the same facility. Punish administrator who sent 805 report for medical cause disciplinary action, but the medical cause was not reviewed by its peer review body.
- Set limits to right to hearings. 3 years later I have state resolution (no problems) but no hospital resolution. Hospitals able to "starve" you out and force you to leave to work elsewhere to feed your family, time for them is "eternal."

If 'other' reasons the organization would allow a provider with repeated allegations raised against them to maintain their practice privileges? Priv_Other_Com, NPS_Priv_Other_Com, RP_Priv_Other_Com

- All allegations would be investigated. If upheld as findings, then practice privileges would be restricted or revoked.
- Allegations are not findings of guilt

- Allegations are reviewed and corroborated to determine whether competence, conduct, or condition is reasonably likely to be detrimental or pose a threat to patient safety or the delivery of patient care. If the allegations are of a significant severity
- Allegations have to be investigated and proven before action is taken
- Difficult process that could involve many hours of legal investigation to resolve. Physicians don't have that amount of time, while trying to maintain a practice. It becomes quite onerous.
- I interpret this question about allegation to mean that concerns have been raised but no evaluated. All of these allegations would be evaluated and then action taken as appropriate
- If allegations are proved to be correct
- If the allegations were not corroborated by appropriate peer review then the provider would maintain their privileges. We would take action on adverse findings in peer review appropriate to the severity and scope.
- The allegations were found repeatedly to be without merit. Note that "allegations" means NOT PROVEN. I can imagine a scenario where some political or interpersonal situation caused repeated allegations to be made which were, on open and fair evaluation
- The peer review process determines: that the allegations are not substantiated, or do not threaten patient care or safety or good order in the organization, or: that verifiable and timely changes in behavior or practice patterns are found to solve the pr
- The word used was allegations, which are unproven events.
- They are only ALLEGATIONS, not until they are FACTS could we take action.
- We would allow the physician to continue participation until Peer Review action taken, question does not make sense. Once Peer Review takes action to terminate or restrict, then physician cannot participate. If the question is designed to see if we tre
- Allegation must be substantiated.
- Allegations mean nothing - evaluation and follow-up must be conducted.
- Allegations must be substantiated before action can be taken.
- Allegations would need to be substantiated; suspension would occur if serious quality of care issues were involved
- Allegations are not substantiated and/or directly impact the quality of patient care
- Allegations must be investigated and confirmed.
- Depends on the severity of the issue and actual determinations made.
- If MBOC allows the provider to maintain their practice privileges
- If the allegations were not substantiated, then the provider would be allowed to continue to practice. If the allegations were substantiated, then the provider would not be allowed to continue to practice.
- If the allegations were substantiated, then he/she would not be allowed to continue to practice. If the allegations were not substantiated, then the provider would be allowed to practice.
- If the allegations raised were determined by review unfounded or identified correctable issues that were addressed by the provider.
- If there is insufficient evidence after thorough internal or external review/investigation of all allegations to support a termination of privileges.
- If there is insufficient evidence to support a termination of privileges after thorough internal and/or external review/ investigation of all allegations.
- It depends on the seriousness of the allegations.
- It there is insufficient evidence after thorough internal or external review/investigation of all allegations to support a termination of privileges.
- Practitioner undergoes due process by Peer Review Committee to evaluate validity of allegation(s)
- Repeat allegations does not equal a reason to take an action. This question is unclear.
- Severity of allegation
- Suspension would occur until allegations have been confirmed.
- The issues do not warrant removal of clinical privileges.

- The provider would be allowed to keep their privileges until such time the repeated allegations were investigated and substantiated. If the allegations posed immediate threat to patients the provider would be summarily suspended pending investigation.
- The question is ambiguous. The organization is bound to enforce the ethical standards.
- The question is very unclear. "Allegations" by definition do not equate to a documented pattern of problems.
- This would only occur after a complete investigation. Your question is misleading.
- Until allegations are investigated and confirmed
- Until allegations are proven
- Whether repeated allegations were founded and/or involved pt care
- Your question is poorly worded
- Allegations are just that. If the facts find that the provider is deficient, action is taken. Allegations are accusations, nothing more.
- Allegations are only allegations and need to be evaluated case by case. One documented QOC case could be grounds for term.
- Allegations have to be substantiated before restricting privileges.
- Allegations were difficult to prove.
- Allegations would need objective support
- Even in repeated allegations, our committee would require reasonable proof of veracity of the allegations.
- If allegations do show any Quality issues on review.
- It depends on what the allegations were.
- No provider should have their practice privileges restricted based on allegations. All allegations of merit are investigated and if true, action is then taken.
- The allegations are false.
- The organization is afraid of personal liability issues
- The question is unclear - are the repeated allegations substantiated or not; if substantiated, then practice privileges would obviously be eliminated or modified. If non-substantiated, then the physician would possibly be monitored depending on the natu
- This is another bad question. Allegations alone are not adequate to take action, other than do peer review of cases that relate to allegations and determine if there is any substance to allegations. Action should be taken only when problems are clearly
- Until the allegations are determined to be factual and harmful to patients/staff, the practitioner can continue
- If the allegations are not substantiated, then the provider would be allowed to continue to practice. If the allegations are substantiated, then he/she would not be allowed to continue to practice. Unsubstantiated allegations would not be used to impose a practice restriction but that substantiated allegations would likely result in a practice restriction. The organization does not make peer review and quality decisions based on the amount of revenue a provider brings, on his or longevity with the organization or for any of the other reasons listed on the form.

Participant Comments via Letters

[redacted]

[redacted]

Jan 11, 2007

RE: Complaint Against [redacted]

Dear Sir:

This is a complaint against the [redacted] and some of their physicians. My charges include false accusations, conspiracy, inappropriate use of Physician Peer Review, and retaliation. I am a [redacted] doctor working in their [redacted] facility.

An outline of the facts is set forth as follows. In May of 2003 I filed a complaint against [redacted] who is the chief of ophthalmology at [redacted] The charges were given to [redacted] who is the physician in chief of the facility and who placed [redacted] in her position as head of the department. My accusations against Dr. [redacted] included incompetence and harassment. After a hearing I received a perfunctory 'apology' from Dr. [redacted] regarding some of the issues but the adverse behavior by Dr. [redacted] continued unabated. Approximately one year elapsed and I filed a second complaint. It fell on deaf ears. Having exhausted the local channels for justice I forwarded formal charges against Dr. [redacted] to [redacted] CEO, Dr. [redacted]. After an investigation

I received a letter saying my issues lacked merit. The notification to me failed to address even one of the many specific concerns that I had raised in my four letters to Dr. [redacted] with supporting data.

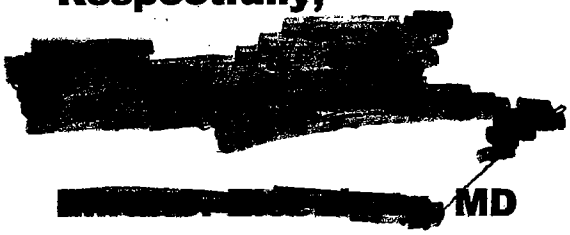
Curiously, after filing my more recent complaints I mysteriously began to receive a multitude of accusatory letters from the Multidisciplinary Peer Review Committee at [redacted]. Cases were submitted calling in question my medical and surgical [redacted] care. While I had been a [redacted] physician for over twenty years at that point I had never had a medical or surgical case reviewed. Furthermore, I have held a continuous medical license in the state of California for thirty years and never had a malpractice action against me. But suddenly I was facing a barrage of poorly researched, poorly documented, and poorly articulated attacks on the 'quality' of my care. None of the submitted cases involved impending legal threats, none involved malpractice suits, none involved direct patient complaints, none were under review from a non-[redacted] third party, and none were supported with ophthalmic research or citations substantiating the basis for the opinions. A colleague verified my beliefs about some of the reviewed files calling the findings "bogus." The patient records had been submitted by or given adverse rulings (significant deviation from the standard of care) by Dr. [redacted].

Dr. [redacted], with [redacted] complicity all the way up the administrative ladder, had discovered a new vehicle to perpetrate goals of retaliation—Physician Peer

Review. The State of California needs to protect the public and physicians from fraudulent accusations. The State of California needs to guard against corporations with individuals acting in concert to effectuate punitive goals under the guise of quality. The State of California needs to insure the Physician Peer Review process is just and not used as a tire iron to bludgeon whistleblowers. The State of California needs to prevent hospitals and health care facilities from making Physician Peer Review a mechanism for retaliation.

I am hopeful that a thorough, detailed, and meticulous examination of this complaint will be instituted along with the appropriate steps to rectify this injustice.

Respectfully,



MD

[redacted]

[redacted]

February 14, 2008

RE: Expansion of my [redacted] Complaint
and Your Letter of 2/4/08

[redacted]

Dear [redacted]:

Your letter to me dated February 4, 2008 was much appreciated. Furthermore, I am grateful you took the time to enclose the relevant law of section 805.2 in the Business and Professions Code. And finally, I salute your decision to share my concerns with the independent entity hired by the Medical Board to study physician peer review.

You will no doubt recall from my initial letter to you that I noted that [redacted] and a group of its physicians were using the peer review process as a retaliatory device. In a nutshell, I filed multiple formal complaints against a chief physician in the [redacted] Department of Ophthalmology, Dr. [redacted], for incompetence and harassment. Shortly after my accusations were made I faced a barrage of cases submitted to peer review deprecating my medical care. After reviewing a number

of these case files I now have additional complaints against [redacted].

Enclosed you will find a letter and analysis that I submitted to the Physician in Chief of [redacted] (Dr. [redacted]) and a physician (Dr. [redacted]) who heads a committee reviewing practitioner reviews. While studying some of the patient files submitted against me (enclosed) I noticed [redacted] was failing to follow my written chart orders, failing to make follow up appointments for patients, and failing to complete testing for patients. These findings are in addition to my original documentation that the cases were poorly written, unjust, devoid of ophthalmic literature citation, and retaliatory. Of course, this was only a small sample set of the files that I scrutinized. The bottom line here is that this is a patient safety issue.

One further point may be helpful that was not disclosed in my original letter to you. Prior to receiving your reply to my original complaint I called the Medical Board to discuss the disposition of my letter. I spoke to a very pleasant informative gentleman in your office named [redacted]. In our conversation I mentioned to him that I am currently and have been an Expert Reviewer in [redacted] for the Medical Board of California for eight years. I have written many decisions on complex situations during that time and served as a testing examiner in addition. [redacted] advised me to disclose that information to you and I am complying with his suggestion.

Based on your last letter I realize the Medical Board of California may not have jurisdiction over my initial or this additional concern. However, I would ask that you continue to use your good judgment and advise me or submit this document to any regulatory agency that would have the appropriate power to rectify this injustice.

Respectfully,

MD

[redacted]

[redacted]

February 8, 2008

[redacted]LIF

2008 FEB 20 PM 2:43

[redacted]

RE: Response to Focused Practitioner Review

Dear Dr[redacted]:

Enclosed you will find my response to Dr. [redacted] letter dated February 1, 2008 and received February 5, 2008. As his letter mandates my response by February 11, 2008 I have received insufficient time to formulate a response to all the charts provided to me for review since they require scrutiny of the old paper charts. The written files, as you are aware, must be ordered and their receipt often takes days. Furthermore, some of the patients have expired and the records were not available for examination. Therefore, analysis of P2 charts is enclosed as these were listed on the Focused Practitioner Review as being a significant deviation from the standard of care. Curiously, all the charts designated are not clear in exactly what in the record falls below appropriate standards of care. In fact, they are not even written in English sentences. Instead, they contain sentence fragments and are poorly written. Furthermore, none cite Ophthalmology literature in support of current practice guidelines, none show meticulous review for what was actually in the record, and none show a practical understanding of how Ophthalmology is practiced. The analysis elucidating these opinions is as follows.

MR# [redacted]– The practice review asserts cataract surgery was done 8/23/05 and no retinal exam was complete after surgery. This is erroneous. The record shows a retinal exam was completed 10/12/25 (within the 6-8 week post operative period for routine IOL surgery).

MR# [redacted] -- The case further states there was no Optometry feedback after the patient was evaluated. That was true. I ordered, in the record, 10/05 that the patient's refraction results were to be sent to me. [redacted] FAILED TO FOLLOW THE ORDER and provide them. While I agree this is inappropriate care it has nothing to do with my care.

MR# [redacted] – The case summary implies no retinal exam was performed. My chart note 9/6/06 orders a return for the patient in one week. [redacted] FAILED TO FOLLOW THE ORDER. In fact, the summary goes on to say a return to clinic directive was also not followed for three months. That is true. In order to adequately perform the elements in my job description I need my orders to be followed.

MR# [redacted] – The chart is cited apparently because an iris defect was not in the operative report. However, an iris defect is recorded in the post operative notes. Why this is clinically relevant is not cited. In fact, the patient enjoys excellent (20/25) acuity in the operated eye. What is not included in this summary is how [redacted] FAILED TO FOLLOW MY ORDER requesting an appointment for this patient on 1/24/07.

MR# [redacted] – The record on this case says there was inadequate panretinal photocoagulation performed and that it was performed 'too slow.' It fails to cite a source stating either the recommended amount or the time duration for this treatment. In fact, the gold standard study for PRP, the DRS (Diabetic Retinopathy Study) used 1200-1500 burns as guidelines for therapy. These are, however, only benchmarks as some cases show neovascular involution with less treatment and some situations require more. The incident case received slightly less than 1400 spots.

MR # [redacted] – This is well within the industry standard for therapy. As to the issue of a treatment delay of over one month to receive this laser care it is noted in the record that another [redacted] physician ([redacted]) saw this patient after the diagnosis/therapy was established. HE FAILED TO INSTITUTE FURTHER THERAPY when he knew or should have known that timely additional treatment was important.

MR #[redacted] – The incident case was seen as a glaucoma suspect with relatively narrow angles and treated immediately. Later (6 months) the patient developed angle closure glaucoma. The complaint is that gonioscopy should have been done on the first day the patient was seen. In fact, a recent ophthalmic survey found 50% of practicing Ophthalmologists don't do gonioscopy at all. Apparently they find it does not add significantly to their practice decisions. Nonetheless, in this case chart review indicates I ordered gonioscopy for a return visit specifically in 1-2 months from the date the patient was initially seen. [redacted] FAILED TO FOLLOW MY ORDER and provide a visit for this gentleman. Furthermore, under what citation or whose authority should gonioscopy be performed on all glaucoma suspects on their first visit? This case review fails to specify.

MR #[redacted] – The case is cited for incomplete panretinal laser photocoagulation. 1210 spots were delivered to the right eye and 1060 to the left eye. As noted in another case the DRS study used 1200-1500 as recommendations for PRP treatment. The right eye received a study dose and the left eye, while receiving slightly less therapy than the usual standard underwent stabilization. No further laser was warranted at that juncture.

MR #[redacted] -- The patient was seen with a suspected

MR #[redacted] – central retinal vein occlusion. The summary note says 'iris' not documented. Since the pupil was dilated no comment would be made. The diagnosis was subsequently confirmed and the occlusion was non-ischemic. The patient (who had good vision) was seen a second time within two months after her initial visit. A four month return was planned. Apparently the case was considered below the standard of care because gonioscopy was not performed and follow up was not frequent enough. In fact, in the slit exam of 11/9/08 I examined the angles (4 mirror) and determined no rubeosis was present. Research has indicated that when a central retinal vein occlusion is 'non ischemic' (as in this case) the long term incidence of neovascularization is less than one in ten. In that the patient was seen 9/18/06, 11/9/06, and 3/07 ---and fell into a low risk catgegory for complications—that meets the burden for excellent care.

MR #[redacted] – The case is so poorly written and so poorly organized chronologically I am unable to discern the complaint. It only indicates neovascular glaucoma was not recognized and treatment was delayed. However, chart review indicates florid rubeosis was documented which is equivalent to neovascular glaucoma. Furthermore, the patient was treated with PRP laser and within 2 weeks had had a full complement of therapy. Since pressure continued to be a problem she was subsequently referred to a glaucoma subspecialist who failed to fix the problem.

MR #[redacted] – The case is raised with an issue of neovascular glaucoma with a delay in completing treatment. Also, the chart is accused of poor documentation with the

MR #[redacted]– statement that "neovascular glaucoma (left eye) could possibly have been prevented with better exams along the way." The three line indictment of sentence fragments with this case, however, fails to disclose the patient failed to show up for clinic visits scheduled 1/30/03, 3/27/03, 8/14/03, 10/9/03, and 1/21/04. The patient's lack of compliance has a definite relation to the quality of exams performed and his overall care.

MR# [redacted] – The record apparently was felt below standard due to a delay in initiating PRP therapy. Chart review indicates I ordered Laser PRP 8/15/00 and the patient did not receive an appointment until 11/15/00. [redacted] FAILED TO PROVIDE TIMELY TREATMENT in this case. Furthermore, a return to clinic appointment was ordered 1/14/01 specifying 4 weeks. [redacted] FAILED TO GIVE THIS PATIENT a follow up visit as directed.

CONCLUSION: These cases, none of which involved a patient complaint to my knowledge, were incompetently submitted, incompetently written, and incompetently reviewed.

Submitted By,

[redacted]

cc: [redacted]

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Peer Review Survey
Physician Was Reviewed Survey

As part of the Medical Board of California Comprehensive Study of the Physician and Surgeon Peer Review Process Project, we are asking that people who have been involved in peer review complete this survey. The answers to the questions will provide us with information about the individual's understanding, experience, and opinions of the organization's Peer Review Process. Thank you for your willingness to answer these questions.

Please provide the following information related to your experience with peer review.

Please select your best response without additional consultation or collecting further data. Be assured that your responses will remain confidential. All the data will be in the aggregate and no individual or organization will be identified. If you have any questions about the survey or the report, please contact:

Jean Ann Seago, PhD, RN
Project Consultant
Lumetra
jseago@lumetra.com
415-677-2160 voicemail
415-677-2185 fax
jseago@lumetra.com

The CMB was great to investigate + closed the case

The following questions are answered regarding how the MEC + hosp did

If you would like to review additional information regarding this project, you can refer to the website: www.lumetra.com/mbc. Please return your survey in the enclosed SASE by March 15, 2008.

1. Organization # (omit this question) [redacted] Hosp, [redacted] Ca

2. Organization Type (select all that apply)
   - Hospital
   - Medical Group
   - Health Plan
   - Professional society

3. Identify your position in the organization related to Peer Review. (omit this question)
   A - Peer Review Body Chair
   B - Physician reviewer for the organization
   C - Physician who has been reviewed
   D - Non-physician organization staff
   E - Attorney who has represented the organization in a peer review
   F - Attorney who has represented a physician being reviewed

No peer review, counseling - Bylaws not followed - State laws were not followed

I was suspended without knowing Why

Peer Review Survey
Physician Was Reviewed Survey

4. Indicate your understanding of the criteria used for filing/not filing an 805 report: (check all that apply)
   - when a peer review body denies or rejects a licentiate's application for a medical disciplinary cause or reason.
   - when a peer review body takes an action that terminates or revokes a licentiate's membership, staff privileges, or employment.
   - when a peer review body imposes or a licentiate voluntarily accepts restrictions on staff privileges, membership, or employment for 30 days or more for any 12-month period, for medical disciplinary cause or reason.
   - after notice of either an impending investigation or the denial or rejection of the application for a membership, privilege, or employment for a medical disciplinary cause or reason
   - resignation or leave of absence, withdrawal or abandonment of a licentiate's application, or request for renewal of privileges or membership.
   - the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.
   - Other criteria, specify

I had no idea when they threatened an 805 unless I resigned - What that was

5. In the last calendar year, estimate the TOTAL AMOUNT of time IN HOURS you lost from practice related to being reviewed by the peer review body in your organization:
   - 0-250 hours
   - 251-500 hours
   - 501-1000 hours
   - 1000-3000 hours
   - ~~greater than 3000 hours~~

6. In the last calendar year, estimate the TOTAL COST IN DOLLARS ($) you spent being reviewed in an 805 or 821.5 peer review process, including legal fees and all other time and staffing costs.
   - $ 0-50,000
   - $ 50,001-250,000
   - $ 250,001-500,000
   - ~~$ 500,000-1,000,000~~
   - greater than $1,000,000

7. Please list the reasons of the highest three costs.

(1) attorney fees approx 500,000
(2) time lost from work due to working on defence
(3) los revenue - unable to deliver babies or do surgery and loss of clients based on rumor & suspension
(5) insurance $7000/quarter to $14500 quarte

Peer Review Survey
Physician Was Reviewed Survey

Do you mean JRC?

15. Identify your understanding of the requirements of 809 hearings: (check all that apply)
    - An arbitrator(s) is selected by a process mutually acceptable to the licentiate and the peer review body or a panel of unbiased individuals, including an individual practicing in the same specialty as the licentiate, who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, fact-finder, or initial decision-maker in the matter. very biased commercial dealing c hosp
    - The right of the licentiate to a reasonable opportunity to challenge the impartiality of the panel members and any hearing officer. Ignored our challenges One MD - personal MD of main
    - The right of the licentiate to inspect and copy relevant documents.
    - The parties shall exchange lists of witnesses at the request of either side. RN who testified
    - Commencing a hearing within 60 days after receipt of the request.
    - None of the above against me + falsified the chart

16. Please list any problems you have experienced with the procedure. Did not get complaints for 3 mo. Found new complaints p/yr.

17. Indicate your recommendations to improve the current peer review process: (check all that apply). These changes might relate to modernization, practicality, patient care, or transparency.
    - No changes necessary
    - Eliminate peer review — needed if neg - refer to
    - Create a statewide government entity that conducts peer review
    - Create a statewide government entity that controls credentialing (not just licensing)
    - Hire an independent organization (non-government) to manage and conduct a peer review
    - 'Other' recommendations, specify:

These possible

Only [redacted] Spanish speaking [redacted] for a mainly hispanic population [redacted] clinic interpreter [redacted] Spanish speaking + took her to meet [redacted] - She was told that she would not get privileges because there were already (3 male [redacted] — The third was hired before my suspension without my knowledge — This was a malicious deprivation of hosp privileges because of precedent + montan

Thank you for completing the survey. Please mail the completed questionnaire in the enclosed SASE. We are also interested in having attorneys for clients who have had an 805 report filed complete a survey. If you would be willing to provide us with the name and address of any attorney who has done work for clients with 805 reports, we will contact that person. Thank you again. Jean Ann Seago

Peer Review Survey
Physician Was Reviewed Survey

8. In the last calendar year, estimate the AMOUNT OF **TIME IN HOURS** you spent **IN EACH PHASE** OF (for preparation of, during the process of, and for monitoring/tracking after) an 805 or 821.5 report proceedings. Proceedings are activities conducted by peer review bodies. This includes aggregate time for the involvement of staff, physician reviewers, legal advisers, and administrators, as well as preparation by physicians or midlevel providers who are being reviewed.

	0-250 hours	251-500 hours	501-1000 hours	1000-3000 hours	Greater than 3000 hours
PREPARATION 5mo	before	JRC	started		✓
DURING THE PROCESS 17	mo of	JRC		✓	
MONITORING/TRACKING				✓ (circled)	

still doing damage control

Save my Board Cert [redacted] 1000-300? repairing + applying

Save my insurance - hosp privs

Trying to keep insurance companies of my patients

Rate the following question on a scale of 1-5 with 1 being the least likely and 5 being the most likely, in your organization. (note: "political" is defined as being used for purposes other than intended, such as, discrimination based on ethnicity or gender, or to remove a competitor)

9. How likely is it that 805 reporting is used for "political" reasons? ("political" meaning for a purpose for which it was not intended)

Malicious deprevation for prejudice against my sex + my response from hispanic population ∴ financial gain

10. If you have experienced or are aware of 805 reporting used for reasons other than intended (ensuring patient safety), please list the reasons.

another MD threatened + just left

Rate the following question on a scale of 1-5, with 1 being the least confident and 5 being the most confident.

11. How confident are you that action will be taken by the MBC once an 805 report has been filed?

Thanks 5 MBC - saw throug + investigating closed case

Rate the following question on a scale of 1-5, with 1 being the least fair and 5 being the most fair.

12. How fair was the peer review process in which you were reviewed?

#1 Kangaroo Court / Lynch Mob mentality

Rate the following question on a scale of 1-5, with 1 being the least timely manner and 5 being the most timely manner.

13. How timely was the peer review process in which you were reviewed?

May [redacted] - Feb [redacted] - 21mo

14. Were you offered the opportunity for an 809 hearing?

- Yes
- No

Following is a brief overview of events related to my suspension. I have deleted the actual testimony from the Judicial Review Committee, but I left the page and line number that relates to the testimony referenced in the body of this report.

On May 5, [redacted] Acting Chief of Staff and [redacted] CEO of [redacted] District's [redacted] Hospital came to my office. [redacted] informed me that a Temporary Restraining Order (TRO) was going to be filed against me and that I was going to be reported to the Medical Board of California unless I resigned within the week. I was shocked. I could not believe what they just said. I replied that I had not done anything and I asked what he was talking about. He replied that a TRO only needed an "implied threat". Earlier that morning I had reported an incident to the night supervisor. I just had a conversation with a nurse who made uninformed accusations and who was extremely rude. I immediately called the night supervisor and asked her to come to the [redacted] department. Nothing occurred that could even be interpreted as an implied threat. The night supervisor was never interviewed and she later declined to testify at the Judicial Review Committee (JRC). I was given no other explanation for the visit to my office. I informed them that I would be getting an attorney.

On May 23, [redacted] my medical and surgical privileges were summarily suspended at [redacted] Hospital. [redacted] is a [redacted] hospital and the only hospital in [redacted] County. The [redacted] District failed to proceed according to its own Bylaws, let alone the laws of the State of California.

I hired [redacted] to represent me in the appeal process. When I first hired Mr. [redacted] he asked me what complaints had been made or what cases the hospital could be concerned about. I merely answered I didn't know. To my knowledge, during my 7 years and 10 months tenure at [redacted], I had never had a complaint made against me. I had never been notified of a complaint (which is required by our bylaws). I had not had a [redacted] case peer reviewed in over three years or an [redacted] case peer reviewed in the previous eighteen months. I had not had a single case that I felt did not met the standard of care per [redacted] guidelines. I was appalled when I read the Notice of Charges. They were <u>not</u> true.

A few days later [redacted] and I went to review my credentialing file because he could not believe that a physician would be suspended without cause. I told him that I did not know of any behavioral issues on which the complaints could have been based. There was not one negative entry in my file. The bylaws at [redacted] give the physician the right to respond to adverse information that appears in their credentialing file within 10 days. A copy of my credentialing file was given to my attorney and me after my suspension. It is pristine. I will forward a copy upon request.

[redacted] filed a petition for a TRO dated May 16, [redacted]. We opposed the petition. Mr. [redacted] requested depositions be taken on June 29, [redacted] He also requested copies of all documentation that was used to support their petition. On June 28, [redacted] the day before the depositions, the petition was withdrawn by [redacted] We did not receive the requested documentation nor were the depositions ever granted.

There were only two [redacted] who practiced at [redacted] Hospital when I was recruited. [redacted] is delightful. He has written a letters of his support since my suspension. The other [redacted], has been in [redacted] for [redacted] years and has a difficult personality. He was never supportive of my recruitment. I have gotten along with him by deferring to him and ignoring his insults. I have included a declaration from a person who went out of her way to contact me after my suspension. The declaration will give you some insight as to [redacted] difficult personality to which I was subjected (Exhibit 1).

After I had been here a year or so, many of the pregnant patients from [redacted] requested to be transferred to me for delivery. The [redacted] clinic patient base is mainly Hispanic Spanish speaking only. I am the only [redacted] that speaks Span[redacted]. [redacted] cornered me in the nurses' lounge. He told me that the patients at [redacted] had to be assigned on a rotating basis. I stated women had the right to choose their provider. Yelling and cussing, he told me that I could not take all the clinic patients and that he was going to report me. With time he made my life so miserable that I relented. In order to keep peace I refused to accept patients out of rotation (Exhibit 2).

[redacted] director of medical staff and the author of the "Statement of Reasons for the Action" in the "Notice of Charges", stated under oath that the bullet points under the behavior issues in the Notice of Charges were taken from her notes of interviews with some of the nurses. [redacted] is not a physician. She also testified under oath, that nothing was done to verify the accuracy of the statements made by the nurses. She prepared the report assuming that the statements by the nurses were absolutely true and correct and presented it to the Medical Executive Committee (MEC) as fact. During the appeal process the nurses' statements were shown to be exaggerations, falsehoods, or stories heard from other staff.

Sworn testimony of [redacted] before the JRC:
P1993-12 P1994-1 P1995-9 P1997-21 P1998-2

The four [redacted] cases listed in the notice of charges were never peer reviewed at [redacted] nor ever discussed with me. Three of the cases dated back to 2004. When a case is presented for peer review a special form is filled out and another [redacted] reviews the case and presents it for discussion. There is no peer review form for any of these cases. The doctor who is having their case reviewed must be notified prior to the review according to the bylaws. In sworn testimony during the JRC, not one person, including the [redacted] chair,

[redacted], could explain how or who chose the cases. How can you possibly suspend a physician on [redacted] cases in which the [redacted] Chair is unaware? Nurse [redacted] testified that [redacted] told her that cases were going to be sent out for review.

Sworn testimony by [redacted] before the JRC: P1759-22
Sworn testimony by [redacted]. before the JRC: P1255-7

On August 20, [redacted], ten months prior to my suspension, I made a verbal complaint against [redacted] the [redacted] director. I complained that I was not treated equal to my male colleagues. [redacted] had called my home that morning and I used her rude behavior via the phone call as an example. [redacted] has worked her entire [redacted] years as a nurse in [redacted] I requested a meeting with [redacted], the [redacted] and later, [redacted], the [redacted] I continued to verbally ask for a meeting with all concerned over the next ten months.

The only response I received was a letter from [redacted] (Exhibit 3). I responded with a letter on February 14, [redacted] (Exhibit 4) demanding an apology for her behavior towards me and for her being less than honest in her letter. Her letter did not state the facts regarding the census and had nothing to do with private patients vs medical patients. I also requested again that we have a meeting to resolve the issue that I was not treated equal to my male colleagues. In [redacted] letter dated September 27, [redacted] which is 8 months prior to my suspension, you will note there is no reference to any behavioral issues or problems that exist between the nurses and me. The letter is apologetic in nature. [redacted] under oath testifies that on August 20, [redacted] I was loud and cussed at the ward clerk in front of the patients when I demanded the patient be moved to a private room. She also testifies that she discussed my language towards the nurses with me when she called my home. If her testimony was factual, why did she not mention my language in the letter? The answer is she did not discuss my language because I did not yell or cuss at the ward clerk. The two patients in the room signed declarations to that fact. One of the patients, [redacted] patient, testified to that fact before the JRC (Exhibit 5).

[redacted] signed a declaration, under penalty of perjury, in the TRO. She later testifies under oath to the JRC that some of that declaration was false. There were numerous discrepancies in [redacted] testimony.

Sworn testimony by [redacted] before the JRC: P1173-16 P1174-21 P1235-17

Sworn testimony by [redacted], a patient, before the JRC: P2976

Sworn testimony by [redacted] before the JRC: P1780- P1781-

Sworn testimony by [redacted] before the JRC:
P2948-18

Neither [redacted] nor [redacted] testified to any language issues regarding this incident, because there were none.

On January 10, [redacted] in a [redacted] meeting (not a peer review) [redacted] accused me of not following the standard of care because I did not cut an episiotomy for a shoulder dystocia case and because I had given fundal pressure while assisting a family physician. No actual complaint or chart was presented at the meeting although [redacted] testifies that he had "two papers". He asked me if I read [redacted] or [redacted] He referenced them as a source for the standard of care. I not only defended my position, but for the very first time I was critical of him stating that he obviously did not stay up on the current literature. A few days later he acknowledged that [redacted] did state that you do not have to do an episiotomy for a shoulder dystocia. That practice bulletin had come out in [redacted]. This was not a peer review meeting. There are no peer review forms for the two cases discussed at that meeting nor did [redacted] review the charts. I was not informed of a peer review of any of my charts prior to this meeting, which is required by the bylaws for peer review. No discussion in the shoulder dystocia case took place at that meeting regarding my charting a wood screw maneuver that the nurses alleged that I did not do. Allegedly falsifying a chart should have been the topic of peer review if the shoulder dystocia case had actually been peer reviewed. [redacted] did not tell me during this meeting that this was peer review and that I could not talk to the nurses although he testifies that he did. [redacted] testifies that it was a general meeting. The secretary taking notes testifies that [redacted] brought the two cases up "out of the blue". During the meeting [redacted] testifies that he encouraged me to speak to the nurses. Why would [redacted] encourage me to speak to the nurses, if [redacted] had warned me not to speak to the nurses?

Sworn testimony of [redacted] before the JRC:
P1948-11 P1955-22

Sworn testimony of [redacted] before the JRC:
P1709-12 P1713-3

Sworn testimony [redacted] before the JRC:
P2949-13 P2930-8

The very next week on January 18, [redacted] went to the MEC with complaints based on hearsay. Under oath he testified that he went to the MEC without talking to me or even reviewing any charts or any documents. He testified that the sole source of the information that he reported to the MEC came from [redacted]. Yet [redacted] testifies that he had documents regarding the shoulder dystocia case and the fundal case at the perinatology meeting on January 10, [redacted], which was the week before the MEC meeting. In his testimony he alleges that this was a peer review meeting. But when questioned about the

how the peer review process works, he states that it was not his intention to make it a formal peer review process. If it was a formal peer review he should have had the nurses' complaints in writing and the findings of the alleged peer review from the previous week, to present to the MEC. No documents regarding any issues surface until months after my suspension under testimony denies reporting any thing to . She also testifies that there are no late deceleration as reported to the MEC by .

Sworn testimony of before the JRC:
P1727-18 P1728-22 P1714-6-17 P1730-2 P1731-1 P1732-3

was the physician that I assisted by doing the fundal pressure. never approached regarding the fundal pressure to verify the complaint by the nurses. He never approached regarding the complaint, even though is also listed on the complaint. reports the nurses' version regarding this case to the MEC without reading the chart, without peer review and without talking to me.

testifies he went to the MEC on January 18, because I was discussing with the nurses what went on in "closed session". The binder and my follow up discussions did not occur until March Without my knowledge I continued to be the topic of the MEC meetings until my suspension on May 23, Under oath who was the chair, stated he never talked to me during that four months regarding any issues. .

Sworn testimony of before the JRC:
P1756-14 P1735-5

Sworn testimony by before the JRC:
P206-1 P206-13 P681-4 P735-3

On March 7, I wrote another letter (Exhibit 6) which discussed the hostile work environment in the department. I especially referenced behavior at the meeting in January of Copies of the letter went to the members of the Department, the CEO, and the Hospital Board. I presented the letter in a binder with an review study done in and current literature from , and numerous articles regarding episiotomies. In the March meeting, I read the letter, as well as a phrase or two from each of the articles, out loud to the members including . Under testimony denies ever having read the letter or the articles. My reading the letter aloud to everyone including is in the minutes of the meeting. It was at this meeting, that that I speak to , the .

Sworn testimony of before the JRC:
P1713-11 P1799-6-14 P1792-2-4 P1758-14

Sworn testimony of before the JRC:
P1758-14

I wrote a second letter to the [redacted] nurses (Exhibit 7) and placed it in another binder with the same literature and review study. After the perinatology meeting I took the binder to [redacted] I left the binder with [redacted]. We discussed whether the review study would breech peer review. She said that she would check before placing it in the [redacted] department. I said the data in the study was taken directly from the [redacted] log book which all nurses make entries in from time to time. All staff in [redacted] has easy access to the log. I told her if there was a problem, just remove it. She encouraged me to talk to the nurses as she was not aware of any complaints. A few days later the binder was placed in [redacted] I have been accused of breeching peer review in regards to placing the binder in [redacted]. I left the binder with the [redacted] and she had it placed [redacted] I was also accused of harassing the nurses for discussing the binder. I think my intent is clearly stated in the letter addressed to the nurses. [redacted] testifies he never read the binder in [redacted] No one removes the binder after is discussed at the MEC in March that the binder contains confidential information. Why didn't [redacted] simply remove it? Why didn't [redacted], who takes the minutes for the MEC and who also had spoken to [redacted] regarding the binder, speak up and tell everyone that I did not place the binder in [redacted]?

Sworn testimony by [redacted] before the JRC:
P2660-8 P2660-22

Sworn testimony by Dr. [redacted] member of MEC, before JRC:
P1605-23 P1635- P1639-17 1654-1

Two months later the binder was still in [redacted] and I was suspended.

During the ten months prior to my suspension, no one ever expressed anything regarding behavioral issues or my clinical skills. I received no response and no action was taken after my numerous requests for a meeting and after my letters. No one ever talked to me regarding any of the concerns that I had raised.

In April, after my letter of March 7, [redacted] I again approached [redacted] the CEO, requesting a meeting regarding the issues in the [redacted] department. He responded with a dismissive attitude. I asked him if I need to get an attorney in order to be heard. He responded with a smirk that "doctors ne[redacted]". A month later I was suspended.

During the JRC, on July 15 [redacted] I requested that my [redacted] privileges be re-instated pending the appeal. On August 22, [redacted] my [redacted] privileges were re-instated and were to remain so unless an amendment to the Notice of Charges substantiated imminent danger to an individual tied to my [redacted] privileges. No amendment was ever made.

I continued to do [redacted] surgery and admissions at Hazel [redacted] Hospital without incident during the 21 months of the appeal process. It has been five years since I had a surgical case before a peer review. [redacted], without

being asked volunteered his opinion regarding my surgical abilities in a negative light to the JRC. The surgical peer review that he referenced under oath took place in October 8, [redacted]. In my entire practice at [redacted] have only had 5 cases go before a surgical peer review in 9 years and I did a lot of surgical cases.

Sworn testimony of [redacted] before the JRC:
P1789-23

The circumstances within and surrounding the [redacted] department at [redacted] Hospital are very political. Not one single complaint came forward because of a patient complaining. Not a single complaint was presented from outside of the [redacted] department even though more than fifty percent of my practice is [redacted]. All complaints from the [redacted] department appeared only after two things occurred.

1. I refused to let my complaints regarding [redacted] regarding my unequal treatment relative to my male colleagues in [redacted] and regarding the hostile environment in [redacted] department be ignored any longer.
2. I refused to defer to or ignore the insults and criticism from [redacted]. Regarding the use of episiotomies during a shoulder dystocia, [redacted] had to acknowledge that I was correct. For his culture and generation, I am sure this was difficult for him.

Per the testimony given under oath by the nurses during the JRC appeal, most of the complaints were at [redacted] direction. [redacted] under oath stated [redacted] said that I was harassing the nurses. He testified that he was surprised that I was "giving nurses a hard time" and that he told the nurses what ever discussions that they had with me that they were to document them and give them to [redacted]. Yet neither [redacted] nor [redacted] talked to me.

Sworn testimony by [redacted] before the JRC:
P1184-19

Sworn testimony by Dr [redacted] before the JRC:
P1789-18 P1743-17 1720-4 721-19 P1723-6 P1749-1
P1750-1 P1728-22

Since I was innocent, I never thought that I would lose in my appeal. My attorney was very confident and was as shocked as I was when I lost. I was in for a rude awakening about the judicial system surrounding a Judicial Review Committee (JRC) and the politics of a small town. I was not aware that I would not have the power to subpoena witnesses before the JRC. Many potential witnesses, especially nurses in the [redacted] department, declined to testify for fear of job security [redacted]. This left vital testimony and facts unheard by the JRC.

The California Medical Board, after a thorough review of all issues pertaining to my medical care and treatment of patients, determined by the facts and the

evidence that there was insufficient cause to warrant pursuing the 805 filed by [redacted] and the case was closed. This information was not allowed to be presented before the JRC. My California Medical license is intact.

The JRC sat for hundreds of hours over a period spanning approximately 18 months listening to testimony. The total number of pages of the transcript of the appeal was greater than 3000 pages. This made it very difficult to decipher the facts or compare testimony between individuals. The JRC, despite their best efforts to come to a fair decision, could not have come to the decision that they came to if they had, like me, spent hundreds of hours reviewing the transcript and comparing the testimonies.

A review of all departments was done as a mandate of JCAHO. The review done in the [redacted] department which spanned almost two years ending is [redacted] showed that I was well within the national averages.

Sworn testimony by [redacted] member of MEC, before JRC:
P1596-20 P1597-8

Sworn testimony by [redacted] before the JRC:
P2934-1

On September 14, [redacted] the Judicial Review Committee upheld the MEC's decision.

I appealed to the Board of Directors of [redacted]. During the appeal, [redacted] the attorney for the MEC, instructed the Board that only my [redacted] privileges and not my [redacted] privileges were before them (pages 59-60 of the transcript in the appeal before the Board of Directors). On February 13, [redacted] the Board of Directors of [redacted] not only upheld the decision to take away my [redacted] privileges, but against the advice of the attorney for the MEC, they took away my [redacted] privileges as well.

On April 15, [redacted] I filed a writ with the Superior Court of [redacted] regarding the action taken by [redacted]. I have notified the National Practitioner Data Bank of my intent to dispute the report and I am in the process of responding now.

The [redacted] is the only insurance company I have used since leaving residency and setting up my private practice. I was notified that due to my suspension that I was going to be dropped. I appealed and after a long investigation I won. I have been practicing now for ten years. I have only been sued one time. I chose to take the case to court. This was a [redacted] with a history of chronic pelvic pain, fibroids and urinary stress incontinence. I did a [redacted] procedure on [redacted]. The patient later developed chronic suprapubic pain. Approximately 10 months post surgery the patient was diagnosed with

interstitial cystitis. She alleged the [redacted] was due to the surgery which was unnecessary. Under oath the patient said she decided to sue me when [redacted] told her that she did not need a hysterectomy. This is on public record at the [redacted] A[redacted] resulted in a verdict of 12-0 in my favor.

Sworn testimony by [redacted] during her trial

P68-20 Q.Did anybody at the hospital suggest to you that you should sue [redacted] A. Yes. Q. And who suggested that to you? A. [redacted]

P70-4 A. He said to me that the hysterectomy should never have been done in the first place.

I am a good person. I am a good and caring physician. I am not a risk to patient safety. My knowledge base is excellent, as are my clinical skills. This has been a horrible ordeal and I did not deserve this. How does a physician, who works for almost eight years without a complaint or incident, develop behavioral problems over two and a half month that are only reported in one department of the hospital? How can a physician be suspended without any notification, warnings or counseling? How does a physician have four cases that are considered substandard in that same department when no peer review took place within that department regarding those cases? Not one nurse who testified could list one time that I did not follow [redacted] guidelines.

The nurses' complaints were that I didn't follow common practice. Some examples that they gave were:

1. That I perform deliveries in the bed without breaking it down
2. I treat a vaginal delivery as a clean procedure not as a sterile procedure [redacted] classifies a vaginal delivery as a clean procedure)
3. I routinely place the baby on the mother's chest prior to a nurse's evaluation when the nurses feel the baby should be handed off to the nurse and evaluated prior to being given to the mom.
4. I rarely do episiotomies causing a delay in delivery and resulting in lacerations ([redacted] says episiotomies should not be done routinely because they increase third and fourth degree lacerations)
5. I waste time by allowing the father to cut the umbilical cord
6. I don't start antibiotics when the patient's temperature is 99° ([redacted] recommends antibiotics at a temperature of 100.4)
7. I don't use betadine on the vagina ([redacted] states that it is toxic to the vaginal tissue)

As you can see, these are all practices that are within the norm of [redacted] practice. But they are different than what the nurses are used to with the other two [redacted]s. That does not make them wrong or dangerous.

[redacted] both endorsed me for my [redacted]. Of interest is that another male [redacted] was recruited by [redacted] without

my knowledge and prior to my suspension. [redacted] also wrote me a letter of recommendation after my suspension.

Sworn testimony of [redacted] before the JRC on 6/21/06: P2938-11

Nine months after my termination I was made aware of six cases that were sent out to the hospital's expert witness [redacted]. These cases had never been discussed with me nor peer reviewed at [redacted] submitted his review on May 2[redacted] the day after I received the "Notice of Charges". Obviously the four clinical cases listed in the "Notice of Charges" are based on [redacted] review. Yet, the wording of the cases presented in the "Notice of Charges" is not exactly what [redacted] states. When [redacted] testified before the JRC, my attorney and I were not aware that one of the nurses had falsified a chart in one case and that documentation was missing from one of the charts in another case, and one of the charts was incomplete. These incorrect charts are what [redacted] had to use for his review. He was actually only critical of one of the cases and this was the case where the nurse actually falsified the chart. Even if I had been negligent in one case, does one case out of thousands of [redacted] cases warrant a suspension? I will not go into detail regarding these cases unless requested.

This has taken a devastating emotional and financial toll and it has affected every aspect of my life. I have endured and continued to fight because I am innocent. This should not happen to another physician. I implore you to look closely at the abuse of reporting an 805 that can be can ruin a physician and prevent him from earning a livelihood.

Thank you

[redacted] M.D.

Sorry I took so long

Exhibit A

3/7/2003

To [redacted] and the members of the [redacted] Committee,

Last meeting two cases that I was involved in were reviewed. Neither of these cases were brought forward through the normal review process. One case was regarding my not cutting an episiotomy during a shoulder dystocia and the other case was regarding my giving fundal pressure during second stage labor. Although I adamantly countered that there was new data to support my actions with the shoulder dystocia, I was told incorrectly that both [redacted] clearly stated an episiotomy should always be made and that I did not follow the standard of care. The other case, involving fundal pressure, I acknowledged held risks. But I also said that fundal pressure was done and that I was trained to use it in my residency. I was told at the meeting fundal pressure should never be done and that again I did not meet the standard of care.

I was attacked in a very unprofessional manner for the above cases. When I attempted to defend my actions based on newer research on episiotomies I was further attacked on a personal level by being told none of the nurses wanted to work with me for fear of jeopardizing their license. No single complaint or case was given to substantiate such a statement although I asked for examples.

I have recently verified the position I took at the meeting. Both [redacted] and [redacted] state that an episiotomy does not have to be done for shoulder dystocia. Shoulder dystocia is a bone on bone impaction and not a soft tissue impediment. For over ten years the research has said that episiotomies increase 3rd and 4th degree tears. The latest research states that episiotomies should never be done except for fetal distress. It is not even necessary for forceps or vacuum deliveries.

Neither [redacted] makes any reference to fundal pressure. Fundal pressure, although controversial, was done in 84% of the hospitals just ten years ago. It is still being done at [redacted] where I did my residency.

When you move from coast to coast or state to state, or even from city to

city, you will see obstetrics being practiced differently. I had never seen a head elevator until I came to [redacted]. When I first came to [redacted] in the summer of [redacted] protocol was just being established. I had been using a [redacted] protocol at [redacted] for four years.

[redacted] did a review study for a period ending in August [redacted] (see attachment). The combined cesarean rate during that time was [redacted], when the national average for [redacted] That statistic leads me to believe that we practice differently than the rest of the nation. The complication rates for obstetrics a[redacted] were listed for each provider in that review study. One of the complications listed was [redacted] I pointed out that being ruptured greater than 24 hours is an increased risk of complication but in itself is not a complication. It is not even an indication for cesarean section. In fact [redacted] itself is not an indication for a cesarean section according to [redacted]. When the complication of being R[redacted] was removed from my complication list (because it is not a complication), the percentage of complications that I incurred was the same as one of my colleagues and within points of the other. My transfer rate for [redacted] was less than one colleague and the same as the other. This makes me believe the complaints of the nurses were unfounded. And I do not understand why my colleagues did not support me and dismiss the nurses' concerns when they were approached about these issues

After leaving last month's meeting I felt completely devastated. Since the meeting, I have felt very uncomfortable [redacted] as it has become a hostile environment for me. I have also felt betrayed by the fact that my colleagues did not defend me and alleviate the nurses' fears. It has come to the point that I have discussed with my husband relocating my practice to a place where I can feel appreciated. He is supportive of any decision I may make.

The anguish that I felt because the meeting was conducted in a manner akin to the Spanish Inquisition was unnecessary. A protocol needs to be established to define how we review cases. I believe these meeting should be a learning opportunity. The point of case review is not to demoralize but rather to guide a colleague. These [redacted] reviews should be done with compassion towards each other and constructive criticism based on scientific data.

If the leading [redacted] practitioners in the country have differences of opinions and methods of practice how can we expect to practice exactly alike?

Attached you will find the Peer Review Study and numerous articles regarding fundal pressure, episiotomies, and episiotomies with shoulder dystocia.

What one physician says about another can have severe consequences in such a small hospital. [redacted] for years after I first came to Hollister you would only sign out to [redacted] even though I was on call. What type of message did that send to the nurses? Every year the new [redacted] is announced. How is this position filled? Why am I not considered? I want to work where I am considered a valued colleague and an equal and my diversity is appreciated. I am a good person and a good doctor. Since the meeting I am feeling none of these. Although I am living in my dream home, I do not feel I can continue to practice the rest of my life in such a hostile environment.

Sincerely,

[redacted]

cc: [redacted]

Exhibit B

To th[redacted] Nursing Staff:

At the last[redacted] meeting, I was told by[redacted] that the nurses in [redacted] had on many occasions sought him out, because he was the [redacted] to express their concerns at assisting with my deliveries. When I questioned him as to who was concerned or which deliveries were referenced, he only replied, "all the nurses" had approached him and that their concerns were over their licenses, especially if they had to assist me with a primagravida. I cannot begin to express the devastation I felt at hearing this. I was also surprised at how distressed and uncomfortable I have felt working i[redacted]ince.

We also discussed two particular cases in which I was involved. Neither of these cases was discussed because of the normal review process. They were discussed because nurses had lodged complaints concerning my handling of the cases. One case involved fundal pressure, which I gave during second stage of labor, and the other case involved a shoulder dystocia in which I did not cut an episiotomy. [redacted] were incorrectly referenced at that meeting and I was told I was wrong in both cases. In fact neither of these references state that fundal pressure should never be done. Both of these references state that an episiotomy does not have to be done for a shoulder dystocia. Shoulder dystocia is a bone on bone impaction and not a soft tissue impediment. For over ten years the research has said that episiotomies increase 3rd and 4th degree tears. The latest research states that episiotomies should never be done except for fetal distress and they need not be done even for forceps or vacuum deliveries. Fundal pressure although controversial was done in 84% of the hospitals just ten years ago. I was taught fundal pressure in my residency a[redacted] [redacted] is still being practiced there today.

When you move from coast to coast or state to state or even from city to city, you will see obstetrics being practiced differently. I had never seen a head elevator which is used for cesarean sections until I came to[redacted] When I first came [redacted] in the

summer o[redacted] protocol was just being established. I had been using [redacted] did a review study for a period ending in Augus[redacted] The [redacted] when the nati[redacted]. That statistic leads me to believe that we practice differently than the rest of the nation.

"Electronic FHR monitoring has been no more effective in reducing the rates of low Apgar scores at birth and long term neurologic morbidity than has intensive intrapartum auscultative monitoring." "The primary risk of electronic FHR monitoring is a potential increase in the cesarean delivery rate." [redacted] If you have questions regarding how I practice obstetrics please feel free to ask me. I will be glad to give you the source by which I choose to practice. If you have a different or new source please share it with me.

The complication rates for [redacted] were listed for each provider in the review study mentioned above. One of the complications listed was R[redacted] I pointed out that being ruptured greater than 24 hours is an increased risk of complication but in itself is not a complication. It is not even an indication for cesarean section. In fac[redacted] itself is not an indication for a cesarean section according to [redacted] When the complication [redacted] s removed from my complication list, the percentage of complications that I incurred was the same as one of my colleagues and within points of the other.

There are numerous articles on how physicians tend to underestimate the amount of bleeding at a[redacted] Because of this, I tend to be generous with my estimations of blood loss. The [redacted] hemorrhage risks listed in the review study were based on each physician's estimation of blood loss and not based o[redacted] hemoglobin values. Therefore the actual rate listed in the review is not based on accurate data.

My transfer rate for sick [redacted] was less than one colleague and the same as

the other.

Attached you will find numerous articles regarding fundal pressure, episiotomies and episiotomies and shoulder dystocia. In the future please feel free to ask me about anything I do which makes you feel uncomfortable. I will be glad to show you the literature which influences my particular practice [redacted]

Sincerely,

[redacted]

Exhibit C

State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
SAN JOSE DISTRICT OFFICE
1735 TECHNOLOGY DRIVE, SUITE 800
SAN JOSE, CA 95110-4313
Office: (408) 437-3600 Facsimile: (408) 437-3693
www.caldocinfo.ca.gov

PERSONAL AND CONFIDENTIAL

May 16, [redacted]

[redacted]

Re: [redacted]

[redacted]

The Medical Board of California has concluded the investigation regarding the suspension of your hospital privileges that was reported on [redacted]

Based upon our investigation, it has been determined by the facts and evidence of this case, that there is not sufficient cause to warrant pursuing an administrative action. Therefore, this case is closed with no further action anticipated.

If you have any questions, feel free to call me. Thank-you for your cooperation in this matter.

Sincerely,

Susan Thadani

Susan Thadani
Senior Investigator
(408) 437-3618

[redacted]

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Appendix X: California Health Plans, Clinics and Hospitals

- Map of California's Rural Hospitals
- List of Critical Access Hospitals in California, April 13, 2007
- Critical Access Hospital Program: Designation Protocol
- Chart Outlining OSHPD, name of organization, county, contact information, and clinic type
- Chart Outlining OSHPD, name of organization, county, contact information, clinic type, number of beds, and EMS level
- List of Small and Rural Hospitals Open as of January 1, 2008
- Department of Managed Health Care List of All Licensed Plans, May 9, 2008

www.oshpd.ca.gov/RHPC/pdf/Ruralhospital/0507HospitalMapWithNames.pdf

California's Rural Hospitals

Rural Hospital Definition in accordance with: Chapter 67/88 (AB 2148) of the California Health and Safety Code and SB 1458, Section 12480 of the California Health and Safety Code, 1987

Map compiled by:
California Rural Health Policy Council
Source:
CA Office of Statewide Health Planning and Development
July 2005

http://www.dhcs.ca.gov/services/rural/Documents/CALIF_CAHs.doc

CRITICAL ACCESS HOSPITALS IN CALIFORNIA

April 13, 2007

HOSPITAL	STATUS	COUNTY
Terry Hansen, Senior Vice-President of Operations **Adventist Health Redbud Community Hospital** Post Office Box 6710 Clearlake,CA 95422 707-994-6486 hansenta@ah.org	**CERTIFIED** Certified 4/05	Lake
Michelle Joy, CEO **Banner Lassen Medical Center** 560 Hospital Lane Susanville, CA 96130 530-257-5325 michelle.joy@bannerhealth.com	**CERTIFIED** Certified 7/1/2005	Lassen
Jim Suver, CEO/Administrator **Biggs-Gridley Memorial Hospital** 240 Spruce Street Gridley, CA 95948 530-846-5671 jsuver@frhg.org	**CERTIFIED** Certified 7/5/02 **Necessary Provider**	Butte
Bryan Ballard, CEO **Catalina Island Medical Center** 100 Falls Canyon Road Avalon, CA 90704 310-510-0700 amdcadmin@catalinaisp.com	**CERTIFIED** Certified 11/01	Los Angeles
Nancy Carlson, Interim CEO **Colorado River Medical Center** 1401 Bailey Avenue Needles, CA 92363 928-788-7252 Nancy.Carlson@LPNT.net	**CERTIFIED** Certified 12/05	San Bernardino
Charles Guenther, CEO		

Eastern Plumas District Hospital **CERTIFIED** Plumas

500 First Avenue ***Certified 10/00***

Post Office Box 1075
Portola, CA 96122
530-832—4277
cguenther@ephc.org

Dwayne Jones, CEO
Fairchild Medical Center **CERTIFIED** Siskiyou
444 Bruce Street Certified 2/05
Yreka, CA 96097
djones@fairchildmed.org

Kevin R. Erich, CEO
Frank R. Howard Memorial Hospital **CERTIFIED** Mendocino

One Mandrone Street ***Certified 5/02***

Willits, CA 95490
707-456-3010
erichk@ah.org

Woody J. Laughnan, Administrator
Glenn Medical Center **CERTIFIED** Glenn
1133 West Sycamore Street Certified 10/01
Willows, CA 95988
530-934-1881
woody.laughnan@glennmed.org

Deborah J. Scaife, CEO
Jerold Phelps Community Hospital **CERTIFIED** Humboldt
733 Cedar Street Certified 3/02

Garberville, CA 95542

707-923-3921 (ext. 231)
dscaife@shchd.org

Elnora George, CEO
John C. Fremont Hospital **CERTIFIED** Mariposa
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Mono

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9/1/2006

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Siskiyou

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CERTIFIED
Certified 2/05

Trinity

Rural Health Clinics in California
2008

Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
053800	WESTERN SIERRA MED CLINIC	209 NEVADA STREET PO BOX 286	DOWNIEVILLE	CA	95936	
053802	UNITED HLTH CTRS-ORANGE COVE	445 11TH ST	ORANGE COVE	CA	93646	2096463561
053803	UNITED HLTH CTRS OF SAN JOAQUIN VALLEY	650 ZEDICKER AVE	PARLIER	CA	93648	2096463561
053804	UNITED HLTH CTRS OF SAN JOAQUIN VALLEY	116900 11TH ST	HURON	CA	93234	2099452541
053812	ORLAND FAMILY HEALTH CENTER	227 SWIFT ST	ORLAND	CA	95963	9168655544
053814	MOUNTAIN EMPIRE FAMILY MEDICINE	31115 HIGHWAY 94	CAMPO	CA	91906	6194785311
053815	FEATHER FALLS HEALTH CENTER	43 CEDAR STREET P O BOX C	FEATHER FALLS	CA	95940	9165891805
053820	SELMA HEALTH CENTER	1041 ROSE AVENUE	SELMA	CA	93662	2098966660
053821	ESPARTO FAMILY PRACTICE	910 S GRAFTON	ESPARTO	CA	95627	9167873454
053825	LONG VALLEY HEALTH CTR	PO BOX 870	LAYTONVILLE	CA	95454	7079846131
053827	LUCERNE VALLEY FAMILY HEALTH CENTER	32866 OLD WOMAN SPRINGS RD	LUCERNE VALLEY	CA	92356	6192487326
053829	CLINICA DE SALUD DEL PUEBLO	341 PAULIN ST	CALEXICO	CA	92231	6193532900
053830	CLINICAS DE SALUD DEL PUEBLO INC	900 MAIN STREET	BRAWLEY	CA	92227	7143446471
053832	SOUTHERN TRINITY HEALTH SERVIC	153A VAN DUZEN ROAD	MAD RIVER	CA	95552	7075746616
053834	COMMUNITY HEALTH CENTER FIREBAUGH	1133 P ST	FIREBAUGH	CA	93622	2096591431
053835	BUTTE VALLEY/TULELAKE RURAL HEALTH CLI	610 W THIRD ST	DORRIS	CA	96023	9163978411
053836	TRI-COMMUNITY MEDICAL OFFICE	310 S OLD WOMAN SPRINGS RD	YUCCA VALLEY	CA	92284	6193642295
053838	TUOLUMNE FAMILY HEALTH SERVICE	PO BOX 1386 TUOLUMNE SQUARE	TUOLUMNE	CA	95379	2099284225
053840	GROVELAND MEDICAL CLINIC	18661 HWY 120	GROVELAND	CA	95321	2099627121
053841	DEATH VALLEY HEALTH CENTER	OLD HIGHWAY 127 P O BOX 158	SHOSHONE	CA	92384	7148524383
053842	EL PROGRESSO DEL DESIERTO	1293 6TH ST	COACHELLA	CA	92236	7143987277
053843	SOUTHERN LASSEN RURAL HEALTH CENTER	CAROL DRIVE	DOYLE	CA	96109	9168272104
053845	PIT RIVER HEALTH SERVICE, INC	36977 PARK AVENUE, PO BOX 2720	BURNEY	CA	96013	9163353651
053846	KAROK TRIBAL HEALTH PROGRAM	GENERAL DELIVERY	FORKS OF SALMON	CA	96031	9164685501
053847	KARUK TRIBAL HEALTH PROGRAM	1519 SOUTH OREGON STREET	YREKA	CA	96097	9164685501
053848	BIG VALLEY MEDICAL CENTER	554-850 MEDICAL CENTER DR PO BOX 27	BIEBER	CA	96009	9162945241
053849	BERRY CREEK HEALTH CTR	BALD ROCK RD TOWNHILL RD	BERRY CREEK	CA	95916	9165892286
053850	TUOLUMNE RURAL INDIAN HLTH CTR	18600 PINE STREET	TUOLUMNE	CA	95379	2099284277
053851	SAN JOAQUIN HEALTH CTR	8669 MAIN ST	SAN JOAQUIN	CA	93660	2096934306
053852	COALINGA COMMUNITY HEALTH CTR	148 W ELM	COALINGA	CA	93210	2099351618
053853	SOBOBA INDIAN HEALTH CLINIC	607 DONNA WAY	SAN JACINTO	CA	92583	7146547612

Rural Health Clinics in California
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Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
053854	MORONGO INDIAN HLTH CLINIC	11555 1/2 POTRERO RD	BANNING	CA	92220	7148494761
053855	TORRES-MARTMEZ INDIAN HEALTH CLINIC	66-235 MARTINEZ RD	THERMAL	CA	92274	6193974476
053858	BUTTE VALLEY/TULELAKE RURAL HLTH	576 MAIN ST	TULELAKE	CA	96134	9166672285
053859	KNIGHTS LANDING FAMILY PRACTICE	405 COUNTY ROAD 116	KNIGHTS LANDING	CA	95645	9167356258
053860	NORTHERN VALLEY INDIAN HLTH INC	HIGHWAY 89 PO BOX 395	GREENVILLE	CA	95965	9162846135
053861	UNITED HLTH CTRS OF THE JOAQUIN VALLEY	476 WASHINGTON AVE	EARLIMART	CA	93219	8058492638
053863	BLYTHE HEALTH CLINIC	321 W HOBSON WAY #C	BLYTHE	CA	92225	7609224981
053864	DIXON FAMILY PRATICE	655 S FIRST ST GATE D	DIXON	CA	95620	9166786227
053865	DARIN M CAMERENA HEALTH CENTER INC	344 EAST 6TH STREET	MADERA	CA	93638	2096740292
053866	NORTH FORK INDIAN AND HLTH CTR	32938 ROAD 222 SUITE #2 P O BOX 1122	NORTH FORK	CA	93643	2098774676
053867	LINDHURST FAMILY HEALTH CENTER	4941 OLIVEHURST AVE	OLIVEHURST	CA	95961	9167434611
053868	SURPRISE VALLEY MEDICAL CLINIC	745 MAIN ST	CEDARVILLE	CA	96104	9162792349
053869	SAN MANUEL INDIAN HLTH CLINIC	5771 N VICTORIA AVE	HIGHLAND	CA	92346	7148623315
053870	SHINGLETOWN MEDICAL CTR INC	31292 ALPINE MEADOWS ROAD	SHINGLETOWN	CA	96088	5304743390
053871	WOODLAKE FAMILY HEATLH CENTER	180 A EAST ANTELOPE	WOODLAKE	CA	93286	5595648067
053872	SAN BENITO HEALTH FOUNDATION	351 FELICE DRIVE	HOLLISTER	CA	95023	4086375306
053873	OROVILLE FAMILY HEALTH CENTER	1453 DOWNER STREET	OROVILLE	CA	95965	9165347500
053874	REDWOOD COAST MEDICAL SERVICES INC	46900 OCEAN DRIVE	GUALALA	CA	95445	7078844005
053875	SAN JOAQUIN HEALTH CENTER	21890 COLORADO AVENUE	SAN JOAQUIN	CA	93660	2096934306
053876	LASSEN INDIAN HEALTH CENTER	745 JOAQUIN STREET	SUSANVILLE	CA	96130	9162572542
053877	TULE RIVER INDIAN HEALTH CENTE	306 NORTH CONYER STREET	VISALIA	CA	93291	5596250844
053878	GRIDLEY FAMILY HEALTH CENTER	2 EAST GRIDLEY RD SUITE B	GRIDLEY	CA	95948	9168466231
053880	TEHAMA COUNTY HEALTH CENTER CLINIC	1850 WALNUT ST	RED BLUFF	CA	96080	9165270350
053881	ANDERSON VALLEY HEALTH CENTER,	13500 AIRPORT RD	BOONVILLE	CA	95415	7078953477
053882	GUADALUPE COMMUNITY HEALTH CENTER, INC	4723 W MAIN STREET, SUITE H	GUADALUPE	CA	93434	8053432004
053883	FEATHER FALLS HEALTH CENTER	43 CEDAR LANE	FEATHER FALLS	CA	95940	9165891805
053884	NIPOMO COMMUNITY MEDICAL CLINIC	150 TEJAS PLACE	NIPOMO	CA	93444	8059293211
053885	BOLINAS FAMILY PRACTICE	7 WHARF ROAD	BOLINAS	CA	94924	4158680124
053886	WILLOW CREEK FAMILY MEDICAL CENTER	38883 HIGHWAY 299	WILLOW CREEK	CA	95573	9166295111
053887	RUSSIAN RIVER HEALTH CENTER INC	16319 THIRD ST	GUERNEVILLE	CA	95446	7078872314
053888	CANBY FAMILY PRACTICE CLINIC	HIGHWAY 299, BOX 322	CANBY	CA	96015	5303355457

Source: CMS, 2008

Rural Health Clinics in California
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Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
053889	INTERMOUNTAIN FAMILY PRACTICE GROUP	20641 COMMERCE WAY	BURNEY	CA	96013	5303355457
053891	REDWOOD RURAL HEALTH CENTER INC	100 WESTCOAST ROAD/P O BOX 769	REDWAY	CA	95560	7079232783
053892	HUMBOLDT OPEN DOOR CLINIC	770 10TH STREET	ARCATA	CA	95521	7078222957
053893	BUTTONWILLOW HEALTH CENTER	277 EAST FRONT STREET	BUTTONWILLOW	CA	93206	8057645211
053894	HILL COUNTRY COMMUNITY CLINIC	ROUTE 299	ROUND MOUNTAIN	CA	96084	9163376243
053895	CLINIC OF SIERRA VISTA	8787 HALL ROAD	LAMONT	CA	93241	8058453731
053896	KERN RIVER HEALTH CENTER	67 EVANS ROAD	WOFFORD HEIGHTS	CA	93285	6193762276
053897	LIVINGSTON COMMUNITY HEALTH SERVICES	1140 THIRD STREET	LIVINGSTON	CA	95334	2093947913
053898	PLUMAS COMMUNITY CLINIC, INC	112 BUCHANON	QUINCY	CA	95971	9162833915
053899	OCCIDENTAL AREA HEALTH CENTER	3802 MAIN STREET	OCCIDENTAL	CA	95465	7078231616
053900	GOLDEN VALLEY HEALTH CENTER - PLANADA	9235 WEST BROADWAY	PLANADA	CA	95365	2093820253
053901	GOLDEN VALLEY HEALTH CENTER-LOS BANOS	821 TEXAS AVENUE	LOS BANOS	CA	93635	2098261045
053903	SABLAN MEDICAL CLINIC	927 O STREET	FIREBAUGH	CA	93622	2096593037
053904	GOLDEN VALLEY HEALTH CENTER-DOS PALOS	1405 CALIFORNIA	DOS PALOS	CA	93620	2093922111
053905	PORTERVILLE FAMILY HEALTH CENTER, INC	1107 W POPLAR AVE	PORTERVILLE	CA	93257	2097817242
053906	REDWOOD COAST MEDICAL SERVICES, INC	46900 OCEAN DRIVE	GUALALA	CA	95445	7078844005
053907	CENTRO DE SALUD FAMILIAR DE FILLMORE	524 1/2 SESPE AVENUE	FILLMORE	CA	93015	8055244926
053908	SATICOY FAMILY HEALTH CARE CENTER	1280 S WELLS ROAD	SATICOY	CA	93004	8056476322
053909	CORCORAN DISTRICT HOSPITAL RHC	1310 HANNA AVE, SUITE 1	CORCORAN	CA	93212	2099925058
053910	CORNING MEDICAL ASSOCIATES	155 SOLANO ST	CORNING	CA	96021	5308244663
053911	PEOPLE'S RURAL CLINIC OF WINTERHAVEN	514 SECOND ST	WINTERHAVEN	CA	92283	6195725090
053912	R DOUGLAS OWEN - RURAL HEALTH CLINIC	465 5TH STREET	COALINGA	CA	93210	2099350813
053913	CLINICA DE SALUD DEL VALLE DE SALINAS	799 FRONT STREET	SOLEDAD	CA	93960	4086780881
053914	MENDOTA FAMILY HEALTH CENTER	507 OLLER STREET	MENDOTA	CA	93640	2096554211
053915	BIG VALLEY MEDICAL CENTER	7711 MARKET ST	BIEBER	CA	96009	9162945241
053916	REDWOOD FAMILY PRACTICE	2350 BUHNE STREET, SUITE A	EUREKA	CA	95501	7074434593
053917	CFP FAMILY PRACTICE	12700 WELCH STREET	WATERFORD	CA	95386	2098742345
053918	AVALON MEDICAL CLINIC	100 FALLS CANYON ROAD	AVALON	CA	90704	2135100096
053919	DEL NORTE COMMUNITY HEALTH CENTER	200 A STREET	CRESCENT CITY	CA	95531	7074656925
053920	EUREKA COMMUNITY HEALTH CENTER	2412 BUHNE STREET	EUREKA	CA	95501	7074411624
053921	SOUTHERN HUMBOLDT COMMUNITY CLINIC	509 ELM ST	GARBERVILLE	CA	95440	7079233925

Source: CMS, 2008

Rural Health Clinics in California
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Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
053922	WASCO MEDICAL CENTER	741 PALM AVENUE	WASCO	CA	93280	8057582263
053923	ALLIANCE MEDICAL CENTER	621 CENTER ST	HEALDSBURG	CA	95448	7074336603
053924	CUTLER-OROSI RURAL HEALTH CLINIC	12683 AVE 416	OROSI	CA	93647	2095284717
053925	HURON MEDICAL GROUP	36617 CENTRAL AVE	HURON	CA	93234	2099459251
053926	PLUMAS COMMUNITY CLINIC, INC	210 MAIN ST	GREENVILLE	CA	95947	9162847136
053928	SILVER LAKES MEDICAL CLINIC	15055 VISTA ROAD, SUITE 7	HELENDALE	CA	92342	6199523099
053929	COMMUNITY HEALTH CENTER	62016 PASO ROBLES HIGHWAY	LOST HILLS	CA	93249	8057972667
053930	FIREBAUGH FAMILY HEALTH CLINIC	944 O STREET	FIREBAUGH	CA	93622	2096593011
053931	MOBILE MEDICAL OFFICE,THE	301 P STREET	EUREKA	CA	95501	7074434666
053932	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	3567 W MT WHITNEY AVE	RIVERDALE	CA	93656	2098674415
053933	MENDOCINO COMMUNITY HEALTH CLINIC, INC	860 N BUSH ST	UKIAH	CA	95482	7074634028
053934	LINDSAY HEALTH CARE CENTER	845 NORTH SEQUOIA	LINDSAY	CA	93247	2095626391
053935	CLNICA DE SALUD DEL VALLE DE SALINAS	808 OAK ST	GREENFIELD	CA	93927	4086745344
053936	FORTUNA FAMILY MEDICAL GROUP	874 MAIN ST	FORTUNA	CA	95540	7077253334
053937	UKIAH VALLEY PRIMARY CARE / ADVENTIST HEALTH	1165 SOUTH DORA STREET, SUITE B1	UKIAH	CA	95482	7074621201
053938	DINUBA HEALTH CENTER	1451 E EL MONTE WAY	DINUBA	CA	93618	2095915858
053939	HILLMAN HEALTH CENTER	1062 SOUTH 'K' ST	TULARE	CA	93274	2096852528
053940	DINUBA MEDICAL CLINIC	271 N L ST	DINUBA	CA	93618	2095911820
053941	HAMILTON CITY MEDICAL CLINIC	231 MAIN ST	HAMILTON CITY	CA	95951	9168263694
053942	KINGS RURAL HEALTH-IRWIN	630 N IRWIN ST	HANFORD	CA	93230	2099925058
053943	ARMONA FAMILY HEALTH CENTER	14054 FRONT STREET	ARMONA	CA	93202	2095836097
053944	KERMAN RURAL HEALTH CLNIC	275 SOUTH MADERA, STE 104	KERMAN	CA	93630	2098464184
053946	HUMBOLDT MEDICAL GROUP, INC	3306 RENNER DRIVE	FORTUNA	CA	95540	7077256101
053947	UKIAH VALLEY PRIMARY CARE / ADVENTIST HEALTH	1050 NORTH STATE STREET	UKIAH	CA	95482	7074681471
053948	DON PEDRO FAMILY PRACTICE	14375 LAS MORAS AVE	LA GRANGE	CA	95329	2098522300
053949	UKIAH VALLEY PRIMARY CARE / ADVENTIST HEALTH	487 S MAIN ST	LAKEPORT	CA	95453	7072634631
053950	UKIAH VALLEY PRIMARY CARE / ADVENTIST	1165 S DORA ST, SUITE G-1	UKIAH	CA	95482	7074680491
053951	FOWLER MEDICAL CENTER INC	210 E MERCED	FOWLER	CA	93625	2098345341
053952	HANFORD HEALTH CLINIC	1004 NORTH DOUTY	HANFORD	CA	93230	2095847545
053953	STEVEN W HARRISON, MD	1180 BROADWAY	KING CITY	CA	93930	8313850922
053954	HAPPY CAMP HEALTH SERVICES, INC	38 PARKWAY/PO BOX 1065	HAPPY CAMP	CA	96039	9164935257

Source: CMS, 2008

Rural Health Clinics in California
2008

Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
053955	EUREKA PEDIATRICS	2800 HARRIS ST	EUREKA	CA	95501	7074458416
053956	UNITED HLTH CTRS OF THE SAN JOAQ VALLY	121 BARBOZA ST	MENDOTA	CA	93640	2096463561
053959	COALINGA MEDICAL GROUP	1145 PHELPS AVENUE, #101	COALINGA	CA	93210	2099351621
053960	KHUSAL MEHTA, MD - RURAL HEALTH CLINIC	430 VERMONT AVE	DINUBA	CA	93618	2095911060
053961	QUINCY FAMILY MEDICAL GROUP	1045 BUCKS LAKE ROAD	QUINCY	CA	95971	9162830650
053962	HANFORD HEALTH CLINIC	1028 DOUTY ST	HANFORD	CA	93230	2095844455
053963	SHELTER COVE COMMUNITY CLINIC	9126 SHELTER COVE ROAD	WHITETHORN	CA	95589	7079233925
053964	GEORGETOWN FAMILY MEDICAL CENTER	6322 HIGHWAY 193	GEORGETOWN	CA	95634	9163331515
053965	DELHI MEDICAL CLINIC	9696 STEPHENS ST	DELHI	CA	95315	2096670702
053966	AVENAL RURAL HEALTH CLINIC	709 N THIRD ST	AVENAL	CA	93204	2093860911
053967	MENDOCINO COUNTY COAST CLINIC	120 W FIR ST	FORT BRAGG	CA	95437	7079611251
053968	BAECHTEL CREEK MEDICAL CLINIC	1245 SOUTH MAIN ST	WILLITS	CA	95490	7074596861
053969	ROBERT RUSHTON, MD RHC	844 S DORA ST	UKIAH	CA	95482	7074628603
053970	PLYMOUTH MEDICAL CENTER	PO BOX 310	PLYMOUTH	CA	95669	2092456968
053971	PATHWAYS HEALTHCARE	190 SOUTH OAK AVE, BLDG 1, SUITE 4	OAKDALE	CA	95361	2098488410
053972	WESTSIDE COMMUNITY HOSP - RHC	151 SOUTH HIGHWAY 33	NEWMAN	CA	95360	2098622951
053973	PARLIER MEDICAL GROUP	501 NEWMARK AVE	PARLIER	CA	93648	2096461200
053974	PIONEER-WEST POINT COMMUNITY HLTH CTR	STATE ROUTE 88	PIONEER	CA	95666	2092955544
053975	FAMILY CARE	315 EAST 13TH STREET	MERCED	CA	95340	2093857060
053980	TEHAMA COUNTY HEALTH CENTER CL	1850 WALNUT ST	RED BLUFF	CA	96080	9165270350
053981	GLENN MEDICAL CENTER FAMILY MEDICAL CENTER	1133 W SYCAMORE	WILLOWS	CA	95988	9169346461
053982	GLENN MEDICENTER - RHC	123 EAST WALKER	ORLAND	CA	95963	9168655100
053983	SURPRISE VALLEY MEDICAL CLINIC	745 MAIN STREET	CEDARVILLE	CA	96104	9162796115
053984	WEST SIDE COMMUNITY DISTRICT HOSPITAL	151 S HIGHWAY 33	NEWMAN	CA	95360	2098622951
053986	AVENAL RURAL HEALTH CLINIC	709 N THIRD STP PO BOX 68	AVENAL	CA	93204	2093860911
053987	WEST VALLEY HEALTH CARE	1145 PHELPS AVENUE	COALINGA	CA	93210	2099356400
053988	MODOC MED CTR - FAMILY PRACTICE CLINIC	229 MCDOWELL STREET	ALTURAS	CA	96101	9162335176
053989	PLUMAS RURAL HEALTH CENTERS	1060 VALLEY VIEW DR	QUINCY	CA	95971	9162832121
053990	FAMILY HEALTH SERVICES ANNEX	1250 EAST ALMOND AVE	MADERA	CA	93639	2096735101
053992	JOHN C FREMONT MEDICAL CLINIC	5189 HOSPITAL ROAD	MARIPOSA	CA	95338	2099663631
053993	CENTRAL VALLEY FAMILY HEALTH/DOUTY	1004 NORTH DOUTY	HANFORD	CA	93230	2095847545

Source: CMS, 2008

Rural Health Clinics in California
2008

Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
053994	CENTRAL VALLEY FAMILY HEALTH/LEMOORE	784 N LEMOORE AVE/P O BOX 240	LEMOORE	CA	93245	5599247711
053995	KINGSBURG RURAL HEALTH CLINIC	1200 SMITH ST	KINGSBURG	CA	93631	2098975841
053996	AVALON MEDICAL CLINIC	100 FALLS CANYON ROAD	AVALON	CA	90704	2135100096
053997	BLOSS MEMORIAL DIST HOSP PRIMARY CARE	1691 THIRD ST, SUITE 7	ATWATER	CA	95301	2093588201
053998	INDIAN VALLEY HOSPITAL	184 HOT SPRINGS ROAD	GREENVILLE	CA	95947	9162846116
053999	ALTA FAMILY HEALTH CLINIC	500 ADELAIDE WAY	DINUBA	CA	93618	2095914171
058500	ARMONA FAMILY HEALTH CENTER	14054 FRONT ST	ARMONA	CA	93202	2095836097
058501	SUTTER AMADOR HEALTH CENTER PLYMOUTH	9279 LOCUST	PLYMOUTH	CA	95669	2092456968
058502	SUTTER AMADOR HEALTH CENTER-PIONEER	24685 ST HWY 88	PIONEER	CA	95666	2092955544
058503	ALTA-MEHTA HEALTH CENTER	430 VERMONT AVE	DINUBA	CA	93618	2095911060
058504	OAKHURST COMMUNITY MEDICAL CTR CLINIC	48677 VICTORIA LANE	OAKHURST	CA	93644	2096832992
058505	HUMBOLDT FAMILY CARE	1733 CENTRAL AVE	MCKINLEYVILLE	CA	95521	7078394347
058506	CORCORAN DISTRICT HOSPITAL , RHC-2	630 N IRQIN ST	HANFORD	CA	93230	2099925051
058507	KINGS RURAL HEALTH-HANNA	1310 HANNA AVE	CORCORAN	CA	93212	2099925051
058508	SAN JUAN HEALTH CENTER	1014 SAN JUAN, SUITE 1 THRU 7	EXETER	CA	93221	5595927314
058511	SOUTHERN INYO HOSP DISTRICT CLINIC	510 EAST LOCUST STREET	LONE PINE	CA	93545	7608765501
058512	SAN BENITO COMMUNITY HEALTH CLINIC	930 SUNSET DRIVE BUILDING #3	HOLLISTER	CA	95023	8316375711
058513	KINGS RURAL HEALTH-VAN DORSTEN	1001 VAN DORSTEN AVENUE	CORCORAN	CA	93212	2099925051
058514	DIVIDE WELLNESS CENTER,THE	6065 HIGHWAY 193	GEORGETOWN	CA	95634	9163332548
058515	WINTON MEDICAL CLINIC	6590 NORTH WINTON WAY	WINTON	CA	95388	2093577755
058516	TULARE COMMUNITY HEALTH CLINIC	1101 CHERRY STREET	TULARE	CA	93274	2096853423
058517	SCOTT VALLEY RURAL HEALTH CLINIC	155 DIGGLES STREET	ETNA	CA	96027	9164675393
058518	EL CENTRO OUTPATIENT CENTER	1745 S IMPERIAL AVE SUITE 106	EL CENTRO	CA	92243	7603703700
058519	SUTTER COAST HEALTH CENTER	785 EAST WASHINGTON BLVD SUITE 10	CRESCENT CITY	CA	95531	7074648511
058520	DEL PUERTO HOSP RURAL HEALTH CLINIC	SOUTH 9TH STREET	PATTERSON	CA	95363	2098928781
058522	PORTOLA MEDICAL/DENTAL CLINIC RHC	480 FIRST AVENUE	PORTOLA	CA	96122	9168324211
058523	MAMMOTH HOSPITAL RURAL HEALTH CLINIC	85 SIERRA PARK ROAD	MAMMOTH LAKES	CA	93546	6199343311
058524	UKIAH VALLEY MED CTR URGENT CARE RHC	275 HOSPITAL DRIVE	UKIAH	CA	95482	7074623111
058525	TAHOE FOREST HEALTH CLINIC	925 NORTH LAKE BLVD SUITE B208	TAHOE CITY	CA	96145	9165835109
058526	RANCHOS FAMILY HEALTH SERVICES	11976 ROAD 37	MADERA	CA	93638	2096755501
058527	KERN VLLY HEALTHCARE DIST RHC #1	6412 LAUREL AVENUE	LAKE ISABELLA	CA	93240	6193792681

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058528	RIVERBANK COMMUNITY HEALTH CENTER	3303 STANISLAUS STREET	RIVERBANK	CA	95367	2098698102
058529	KIDS CARE	200 EAST 15TH STREET	MERCED	CA	95340	2093857100
058530	GENERAL MEDICINE CLINIC	1248 NORTH D STREET	MERCED	CA	95340	2097253939
058531	HUGHSON MEDICAL OFFICE - RURAL HEALTH	2430 THIRD STREET	HUGHSON	CA	95326	2095587251
058532	BERRY CREEK HEALTH CENTER	10 TOWN HILL WAY PO BX 40	BERRY CREEK	CA	95916	9165892285
058533	REDBUD COMMUNITY HOSPITAL FAMILY HEALTH CE	15230 LAKESHORE DRIVE	LOWER LAKE	CA	95457	7079940407
058534	CAL CITY CLINIC	9350 NORTH LOOP BLVD	CALIFORNIA CITY	CA	93505	6193731256
058535	MCH MEDICAL CLINIC	29099 HOSPITAL ROAD	LAKE ARROWHEAD	CA	92352	9093363651
058536	CALEXICO OUTPATIENT CENTER	2451 ROCKWOOD AVE, SUITE 101	CALEXICO	CA	92231	7603703700
058537	CASTLE MEDICAL CLINIC	3605 HOSPITAL ROAD, BLDG 1182	ATWATER	CA	95342	2093812009
058538	MERCY WESTSIDE WELLNESS CENTER	100 EAST NORTH STREET	TAFT	CA	93268	8058633141
058539	DELANO REGIONAL MEDICAL CENTER RURAL HEAL	2300 7TH STREET	WASCO	CA	93280	6617584184
058540	SIERRA FAMILY HEALTH CARE CLINIC	1471 N ACACIA 101	REEDLEY	CA	93654	2096388155
058541	WILLOW CREEK FAMILY HEALTH CENTER	38883 HIGHWAY 299	WILLOW CREEK	CA	95573	9166293111
058542	SPMH RURAL HEALTH CENTER	254 WEST HARVARD BOULEVARD	SANTA PAULA	CA	93060	8059339131
058543	LA PALOMA HEALTH CENTER	1574 KIRK ROAD	GRIDLEY	CA	95948	9165328550
058544	SUTTER LAKESIDE WOMENS AND CHILD	5196 HILL ROAD EAST	LAKEPORT	CA	95453	7072625001
058545	SIERRA FAMILY MEDICAL CLINIC	725 THIRD STREET	LOYALTON	CA	96118	9169931225
058546	GALT MEDICAL SERVICES	387 CIVIC DRIVE	GALT	CA	95632	2093397560
058547	SUTTER LAKESIDE COMMUNITY HEALTH CTR	750 OLD LUCENRE ROAD	UPPER LAKE	CA	95485	7072759066
058548	COPPEROPLIS FAMILY MEDICAL CENTER	3505 SPRANGLER LANE #400	COPPEROPOLIS	CA	95228	2097897000
058549	COTTONWOOD COMMUNITY CLINIC	20633 GAS POINT ROAD	COTTONWOOD	CA	96022	9169642246
058550	COLUSA COMMUNITY HOSPITAL RHC	900 KING STREET	ARBUCKLE	CA	95912	9164762228
058551	COLUSA HEALTH CLINIC	2967 DAVISON COURT, SUITE A	COLUSA	CA	95932	9164585003
058552	CENTRAL VALLEY FAMILY HEALTH/CORCORAN	1212 HANNA STREET	CORCORAN	CA	93212	5599922800
058553	OAK VIEW FAMILY PRACTICE	655 N VENTURA AVE	OAK VIEW	CA	93022	8056493750
058554	CENTRAL VALLEY FAMILY HEALTH/MOBILE	75 5TH STREET	KETTLEMAN CITY	CA	93239	5595832135
058555	KINGS HEALTH MOBILE SERVICES	20799 SOUTH FOWLER	LATON	CA	93242	2095855157
058556	URGENT CARE CENTER	900 ORO DAM BLVD	OROVILLE	CA	95965	9165349183
058557	SONORA COMMUNITY HOSPITAL	ONE SOUTH FOREST ROAD	SONORA	CA	95370	2095323161
058558	MEE MEMORIAL HOSPITAL MEDICAL CLINIC	467 EL CAMINO ROAD	GREENFIELD	CA	93927	8316740112

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058559	KINGS RURAL HEALTH WHITLEY	1320 WHITLEY AVENUE	CORCORAN	CA	93212	2099921377
058560	SAMUEL BURRE MEMORIAL CLINIC	2200 HARRISON AVENUE	EUREKA	CA	95501	7074432293
058561	KERN VLLY HEALTHCARE DIST RHC #2	4300 BIRCH AVENUE	LAKE ISABELLA	CA	93240	7603791791
058562	MEE MEMORIAL HOSPITAL MEDICAL CLINIC	210 CANAL STREET	KING CITY	CA	93930	8313856000
058563	SPMH RURAL HEALTH CLINIC	552 SESPE AVENUE	FILLMORE	CA	93015	8055249522
058564	FAMILY HEALTH CENTER RHC	370 SUMMIT BLVD	BIG BEAR LAKE	CA	92315	9098788246
058565	LOS MOLINOS FAMILY HEALTH CENTER	7883 HIGHWAY 99E, PO BOX 477	LOS MOLINOS	CA	96055	5303842372
058566	ADVENTIST HEALTH MOUNTAIN LAKE	3400 EMERSON STREET	CLEARLAKE	CA	95422	7079945272
058567	ADVENTIST HEALTH EAST LAKE MED CLINIC	13050 HIGH VALLEY ROAD	CLEARLAKE OAKS	CA	95423	7079982250
058568	SIERRA KINGS FAMILY HEALTHCARE-DINUBA	250 W EL MONTE AVENUE	DINUBA	CA	93618	5596388155
058569	SIERRA KINGS FAMILY HEALTHCARE-NEWMARK	155 S NEWMARK	PARLIER	CA	93648	5599646120
058570	SIERRA KINGS FAMILY HEALTH CARE	826 E MANNING AVENUE	REEDLEY	CA	93654	2093382566
058571	VALLEY SPRINGS FAMILY MEDICAL CLINIC	1919 VISTA DEL LAGO	VALLEY SPRINGS	CA	95252	2097729538
058572	GLENN FAMILY MEDICAL GROUP	130 NORTH ENRIGHT	WILLOWS	CA	95988	5309344681
058573	ARNOLD MEDICAL CLINIC	2182 HIGHWAY 4, SUITE A100	ARNOLD	CA	95223	2097954193
058574	ANGELS CAMP MEDICAL CENTER	222 SOUTH MAIN STREET	ANGELS CAMP	CA	95222	2097360813
058575	COMMUNITY FOR YOUTH CUTLER OROSI	40729 ROAD 128	CUTLER	CA	93615	5595927392
058576	GOSHEN COMMUNITY CENTER	6678 AVENUE 308 & ROAD 62	GOSHEN	CA	93227	5596511030
058577	ALTA DISTRICT HOSPITAL RHC	500 ADELAIDE WAY	DINUBA	CA	93618	5595914171
058578	NORTHERN INYO HOSPITAL RURAL HEALTH CLINIC	150 PIONEER LANE	BISHOP	CA	93514	7608735811
058579	TDHS MOBILE HEALTH CLINIC	300 NORTH SCHOOL	PIXLEY	CA	93256	5596853413
058580	BARTON MEMORIAL HOSPITAL COMM CLINIC	2170 SOUTH AVENUE	SOUTH LAKE TAHOE	CA	96158	5305427094
058581	OROVILLE FAMILY PRACTICE	2809 OLIVE HIGHWAY, SUITE 320,310,350,2	OROVILLE	CA	95966	5305328687
058582	OVOVILLE PEDIATRIC PRACTICE	2809 OLIVE HIGHWAY, #270	OROVILLE	CA	95966	5305334422
058583	OROVILLE PEDIATRIC ASSOCIATES	2809 OLIVE HIGHWAY, SUITE 330	OROVILLE	CA	95966	5305330774
058584	PREMIER HEALTH CENTER	900 ORO DAM BOULEVARD	OROVILLE	CA	95966	5305328824
058585	FAMILY PRACTICE ASSOCIATES	2809 OLIVE HIGHWAY SUITE 260	OROVILLE	CA	95966	5305326588
058586	MIDDLETOWN MEDICAL CLINIC	21337 BUSH STREET	MIDDLETOWN	CA	95461	7079873311
058587	FEATHER RIVER HOSP FAMILY HEAL	5730 CANYON VIEW DRIVE	PARADISE	CA	95969	5308763179
058588	DELANO WOMEN'S MEDICAL CLINIC	1201 JEFFERSON STREET	DELANO	CA	93215	6617210737
058589	SIERRA KINGS FAMILY HEALTHCARE-CAROB CLINIC	326 WEST CAROB STREET	REEDLEY	CA	93654	5596372384

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058590	HAZEL HAWKINS HEALTH CLINIC	301 THE ALAMEDA, SUITE B3	SAN JUAN BAUTISTA	CA	95045	8316375711
058591	CORCORAN DISTRICT HOSPITAL HEALTH CENTER	1310 HANNA AVENUE, SUITE 3	CORCORAN	CA	93212	5599925051
058592	CENTRAL VALLEY FAMILY HEALTH-CARUTHERS	2440 WEST TAHOE	CARUTHERS	CA	93609	5598643212
058593	SENECA HEALTHCARE DISTRICT LAKE ALMANOR CI	199 REYNOLDS ROAD	CHESTER	CA	96020	5302582067
058594	FEATHER RIVER HOSPITAL CANYON VIEW CLINIC	5734 CANYON VIEW DRIVE	PARADISE	CA	95969	5308722000
058595	CENTRAL VALLEY FAMILY HEALTH-FOWLER	119 SOUTH SIXTH STREET	FOWLER	CA	93625	5598341614
058596	CENTRAL VALLEY FAMILY HEALTH-COALINGA	155 S 5TH STREET	COALINGA	CA	93210	5599354282
058597	EASTERN PLUMAS HOSPITAL - LOYALTON MEDICAL	725 THIRD STREET	LOYALTON	CA	96118	5309931225
058598	DOS PALOS MEMORIAL RURAL HEALTH CLINIC	2118 MARGUERITE STREET	DOS PALOS	CA	93620	2093926121
058599	CENTRAL VALLEY FAMILY HEALTH-KERMAN	1000 SOUTH MADERA AVENUE	KERMAN	CA	93630	5598469370
058600	CENTRAL VALLEY FAMILY HEALTH-LEMOORE EAST	810 E 'D' STREET	LEMOORE	CA	93245	5595832271
058601	OROVILLE HOSPITAL - MEDICAL CLINIC	2767 OLIVE HIGHWAY, ANNEX BUILDING	OROVILLE	CA	95965	5305328544
058602	KINGS RURAL HEALTH MOBILE SERVICES	11545 SOUTH 10TH AVE	HANFORD	CA	93230	5595832167
058603	CHARLIE MITCHELL CLINIC	41169 GOODWIN WAY, RM 100	MADERA	CA	93638	5593536430
058605	JOHN C FREMONT HEALTHCARE DISTRICT-RHC II	5186 HOSPITAL ROAD	MARIPOSA	CA	95338	2099663631
058606	ESCALON COMMUNITY HEALTH CLINIC	2080 MCHENRY AVENUE #100	ESCALON	CA	95320	2098473011
058607	CALEXICO HEALTH CENTER	450 EAST BIRCH STREET	CALEXICO	CA	92231	7607686262
058608	CMH CENTER FOR FAMILY HEALTH - FILLMORE	852 VENTURA ST	FILLMORE	CA	93015	8055242672
058609	CMH CENTER FOR FAMILY HEALTH - SANTA PAULA	242 E HARVARD BLVD STE C	SANTA PAULA	CA	93060	8056525490
058610	CENTRAL VALLEY FAMILY HEALTH SELMA CENTRAL	2141 HIGH STREET	SELMA	CA	93662	5598918940
058611	CENTRAL VALLEY FAMILY HEALTH-HURON	16916 5TH STREET	HURON	CA	93234	5599459090
058613	CENTRAL VALLEY FAMILY HEALTH/DINUBA	1451 E EL MONTE WAY	DINUBA	CA	93618	5595913342
058618	TRINITY COMMUNITY HEALTH CLINIC	60 EASTER AVENUE	WEAVERVILLE	CA	96093	5306235541
058620	TEHACHAPI FAMILY HEALTH CENTER-CALIFORNIA C	9350 NORTH LOOP BOULEVARD	CALIF CITY	CA	93505	7603731785
058621	SIERRA KINGS FAMILY HEALTH CARE-ORANGE COV	1455 PARK BLVD	ORANGE COVE	CA	93646	5596388155
058900	HORISONS UNLIMITED HEALTH CARE-GUSTINE	554 5TH STREET	GUSTINE	CA	95322	2098543854
058901	DEL PUERTO HEALTH CENTER	1108 WARD AVENUE, BLDG A, SUITE 1	PATTERSON	CA	95363	2098929100
058902	CAL FAMILY HEALTH, INC	1415 N ACACIA, SUITE 101	REEDLEY	CA	93654	5596388187
058904	KAIN KUMAR MD, INC	16914 HIGHWAY 14	MOJAVE	CA	93501	6618248282
058905	MEDICOS UNIDOS DE HURON	36618 S LASSEN DRIVE	HURON	CA	93234	5599059000
058906	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	2357 W TAHOE	CARUTHERS	CA	93609	5598645200

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058907	JOHNSTON, CHRISTINE MARIE MD INC	552 SESPE AVE STE C	FILLMORE	CA	93015	8055242000
058908	APEX MEDICAL GROUP, INC	311 WEST I STREET	LOS BANOS	CA	93635	2098262222
058909	WESTERN SIERRA MEDICAL CENTER	3070 CAMINO HEIGHTS DRIVE, SUITE B	CAMINO	CA	95709	5306479762
058910	TEHAMA COUNTY HEALTH CENTER CL	1850 WALNUT ST	RED BLUFF	CA	96080	9165270350
058911	HORISONS UNLIMITED HEALTH CARE	2275 F STREET, SUITE 1 & 2	LIVINGSTON	CA	95334	2093948854
058912	CHILDREN'S CLINIC	348 MARKET STREET, SUITE B	COLUSA	CA	95932	5304582300
058913	RIGOBERTO O GUTIERREZ, MD	2809 OLIVE HWY #370	OROVILLE	CA	95966	5305389410
058914	MEDICOS UNIDOS DE STRATHMORE	19757 ORANGE BELT DRIVE	STRATHMORE	CA	93267	5595681200
058915	VIDA SANA MEDICAL GROUP, INC	755 NORTH SEQUOIA AVENUE, SUITE B	LINDSAY	CA	93247	5595629399
058916	WESTSIDE MEDICAL GROUP OF MENDOTA, INC	450 OLLER STREET, STE 101	MENDOTA	CA	93640	5596551000
058918	LINDSAY FAMILY AND PEDIATRIC CLINIC	825 NORTH SEQUOIA	LINDSAY	CA	93247	5595621960
058920	BEST HEALTHCARE CENTER	134 DAVIS STREET	PIXLEY	CA	93256	5599922337
058922	FIRST CARE MEDICAL ASSOCIATES, INC	203 WALKER STREET SUITE 3	ORLAND	CA	95963	5308654400
058924	TAFT RURAL MEDICAL GROUP, INC	501 6TH STREET	TAFT	CA	93268	6616642636
058925	OROSI URGENT CARE CENTER MEDICAL CLINIC, INC	41696 ROAD 128	OROSI	CA	93647	5595286966
553800	MADERA COUNTY MOUNTAIN HEALTH CENTER	40131 HIGHWAY 49 SOUTH	OAKHURST	CA	93644	2096587456
553801	WOODLAKE RURAL HEALTH CLINIC	345 NORTH VALENCIA	WOODLAKE	CA	93286	2095647301
553802	IMMEDIATE HEALTH CARE, RHC	1850 WHITSON AVE	SELMA	CA	93662	2098966666
553803	ROBERT MOTT, MD	1735 CENTRAL AVE	MC KINLEYVILLE	CA	95521	7078394347
553804	PIONEER-WEST POINT COMM HEALTH CTR	STATE ROUTE 88	PIONEER	CA	95666	2092955544
553805	SAN JOAQUIN PRIME CARE MEDICAL CORP	326 W CAROB	REEDLEY	CA	93654	2096382566
553806	QUINCY MEDICAL ASSOCIATES	1060 VALLEY VIEW DRIVE	QUINCY	CA	95971	9162833392
553807	SAGE COMMUNITY HEALTH CENTER	1041 NORTH CHINA LAKE BLVD	RIDGECREST	CA	93555	7604467978
553809	CORNING FAMILY AND URGENT CARE	1120 SOLANO ST	CORNING	CA	96021	9168242114
553810	PLACER COUNTY MEDICAL CLINIC	11583 C AVENUE	AUBURN	CA	95603	9168897215
553811	PRIMARY CARE CONSULTANTS, INC	49063 RD 426 STE C AND D	OAKHURST	CA	93644	2096421500
553812	BANNING HEALTH CENTER	3055 WEST RAMSEY	BANNING	CA	92220	9098496794
553813	LAKE ELSINORE FAMILY CARE CENTER	30195 FRASER DRIVE	LAKE ELSINORE	CA	92530	9092453388
553814	MOUNTAIN LAKE FAMILY HEALTH CENTER	3400 EMERSON STREET	CLEARLAKE	CA	95422	7079945272
553816	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	1239 ROSE AVENUE	SELMA	CA	93662	2098674415
553817	DINUBA MEDICAL CENTER	247 NORTH L STREET	DINUBA	CA	93618	5595911820

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553818	SHAFTER RURAL HEALTH CARE CLINIC	406 JAMES STREET	SHAFTER	CA	93263	6617465788
553819	SHAFTER RURAL HEALTH CARE CLINIC	565 KERN STREET	SHAFTER	CA	93263	6617464937
553820	SEQUOIA FAMILY MEDICAL CENTER RHC	590 W PUTNAM AVE	PORTERVILLE	CA	93257	5597814100
553821	MEDICAL GROUP OF REEDLEY	1311 11TH STREET	REEDLEY	CA	93654	2096378888
553822	SAN JOAQUIN PRIME CARE MEDICAL CORP	330 EAST PINE STREET	EXETER	CA	93221	5595922134
553823	EASTERN MADERA MEDICAL CENTER	32938 ROAD 222	NORTH FORK	CA	93643	2096830400
553824	COPPER TOWERS FAMILY MEDICAL CLINIC	240 N CLOVERDALE BLVD	CLOVERDALE	CA	95425	7078944229
553825	PIXLEY MEDICAL GROUP	205 EASE DAVIS, DRAWER Y	PIXLEY	CA	93256	5597572000
553826	PARLIER MEDICAL GROUP	501 NEWMARK AVE	PARLIER	CA	93648	2096461200
553827	MIDDLETOWN MEDICAL CLINIC	21337 BUSH ST	MIDDLETOWN	CA	95461	7079873311
553828	NORTH COAST FAMILY HEALTH CENTER	721 RIVER DRIVE, SUITE A	FORT BRAGG	CA	95437	7079647241
553829	KRISHNAMOORTHI MD INC, A PROFESSIONAL MEDI	324 F STREET	WATERFORD	CA	95386	2098742321
553830	KRISHNAMOORTHI MD INC, A PROFESSIONAL MEDI	850 WEST CALIFORNIA ST	ESCALON	CA	95320	2098382278
553831	KERMAN MEDICAL GROUP	275 SOUTH MADERA AVE, #104	KERMAN	CA	93630	2098464184
553832	ANDERSON MEDICAL ASSOCIATES	2830 EAST STREET	ANDERSON	CA	96007	9163652545
553834	DINUBA RURAL HEALTH CLINIC	420 E EL MONTE	DINUBA	CA	93618	2095959500
553835	BEVERLY MEDICAL CENTER, INC	9300 NORTH LOOP BLVD, STE B	CALIF CITY	CA	93505	7603823505
553836	REDWOOD PEDIATRIC MEDICAL GROUP	3305 RENNER DRIVE	FORTUNA	CA	95540	7077259355
553837	LINDSAY RURAL HEALTH CLINIC	755 NORTH SEQUOIA	LINDSAY	CA	93247	2095621343
553838	MARIPOSA CROSSROADS MEDICAL CLINIC	5004-B HIGHWAY 140	MARIPOSA	CA	95338	2097426655
553839	OAKHURST FAMILY/WOMEN HEALTH CLINIC	49063 RD 426, PROFESSIONAL CTR, STE C	OAKHURST	CA	93644	2096421430
553840	ROSS TYE, MD AND ASSOCIATES	1361 CORTINA DRIVE STE A	ORLAND	CA	95963	9168653400
553841	WEST SHORES MEDICAL CLINIC	455 SOUTH MARINA W S22	SALTON CITY	CA	92275	7603944639
553842	JEFFREY BERENSON, MD, RHC	45081 LITTLE LAKE ROAD	MENDOCINO	CA	95460	7079371055
553843	MENDOCINO COAST PEDIATRIC GROUP	510-D CYPRESS ST	FORT BRAGG	CA	95437	7179645696
553844	TRONA COMMUNITY HEALTH CENTER	82824 TRONA ROAD	TRONA	CA	93562	6194467978
553845	HI-DESERT FAMILY MED CLINIC	57252 29 PALMS HWY	YUCCA VALLEY	CA	92284	6193693069
553846	HEALTH VALLEY MEDICAL GROUP INC	812 EAST D STREET	LEMOORE	CA	93245	2099251000
553847	WOMEN'S HEALTH CENTER	850 SEQUOIA CIRCLE	FORT BRAGG	CA	95437	7079640259
553848	LINDSAY URGENT CARE	973 NORTH SEQUOIA AVE	LINDSAY	CA	93247	5595629395
553849	EUREKA PEDIATRICS MCKINLEYVILLE CLINIC	2192 CENTRAL AVENUE SUITE A	MCKINLEYVILLE	CA	95521	2097777777

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553850	HIGH DESERT FAMILY MEDICINE	44460 OLD HWY 80	JACUMBA	CA	91934	6197664107
553851	EXETER RURAL HEALTH CENTER	1014 SAN JUAN SUITE A	EXETER	CA	93221	2095929555
553852	STEVENS PARKVIEW HEALTH CARE	535 SOUTH MAIN STREET	ALTURAS	CA	96101	9162332288
553853	BEST CARE MEDICAL GROUP	15065 VISTA ROAD	HELENDALE	CA	92342	6199521222
553854	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	205 C STREET	LEMOORE	CA	93245	2099247200
553855	SONOMA VALLEY COMMUNITY CENTER	430 WEST NAPA STREET #F	SONOMA	CA	95476	7079396070
553856	MT SHASTA MEDI-CAL CLINIC	912 PINE STREET	MOUNT SHASTA	CA	96067	9169265105
553857	BEVERLY MEDICAL CENTER II	1415 ROSAMOND BLVD SUITE 24	ROSAMOND	CA	93560	6612561866
553858	VALLEY FAMILY MEDICAL CARE	333 SOUTH 10TH STREET	TAFT	CA	93268	8053272225
553859	RIVERBANK PRIMARY CARE CLINIC	3227 STANISLAUS ST SUITE A	RIVERBANK	CA	95367	2098690131
553860	HEALTH CARE MEDICAL ASSOCIATES INC	2192 CENTRAL AVENUE	MCKINLEYVILLE	CA	95521	7078395955
553861	HEALTH CARE MEDICAL ASSOCIATES	2787 HARRIS STREET	EUREKA	CA	95503	7074443100
553862	GATEWAY MED CTR DBA ANDERSON WALK-IN MEDI	2760 BALLS FERRY ROAD	ANDERSON	CA	96007	9163654412
553863	SISKIYOU MEDICAL GROUP	4309 STAGE COACH ROAD	DUNSMUIR	CA	96025	9162352205
553864	SISKIYOU MEDICAL GROUP	50 ALAMO AVENUE	WEED	CA	96094	9169383491
553865	COMMUNITY COMPREHENSIVE CARE	1611 FEATHER RIVER BLVD SUITE 10	OROVILLE	CA	95965	9165344530
553866	DE ANZA CLINIC	1001 BLAIR STREET	CALEXICO	CA	92231	7603577867
553867	PLACER MEDICAL CLINIC	PO BOX 1707 8665 SALMON STREET	KINGS BEACH	CA	96143	9165466356
553868	NAPA VALLEY FAMIL MEDICAL GROUP	1705 WASHINGTON STREET	CALISTOGA	CA	94515	7079426219
553869	ARTURO Z ABALOS MD INC	1004 14TH AVENUE	DELANO	CA	93215	6617255676
553871	MARIPOSA FAMILY MEDICINE ASSOCIATES	5300 HWY 49N PO BOX 155	MARIPOSA	CA	95338	2099663672
553872	LA PALOMA HEALTH CENTER	1574 KIRK ROAD	GRIDLEY	CA	95948	9168463696
553873	MADERA MEDICAL ASSOCIATES	1050 EAST ALMOND	MADERA	CA	93637	2096735181
553874	INTERMOUTAIN FAMILY PRACTICE GROUP	HWY 299 E HOSP ANNEX	FALL RIVER MILLS	CA	96028	9163366535
553875	UKIAH VALLEY PRIMARY CARE / ADVENTIST HEALTH	1165 SOUTH DORA STREET, SUITE E1 & E	UKIAH	CA	95482	7074638000
553876	INTERMOUNTAIN FAMILY PRACTICE GROUP	37394 CASCADE AVENUE	BURNEY	CA	96013	9163352954
553877	BRIDGEVILLE HEALTH CLINIC	38717 KNEELAND ROAD	BRIDGEVILLE	CA	95526	7077773456
553878	WESTWOOD WALK IN CLINIC	2975 EAST STREET	ANDERSON	CA	96007	9163659448
553879	REDWOODS RURAL HEALTH CENTER	313 5TH STREET	ALDERPOINT	CA	95511	7079261070
553880	FIRST CARE MEDICAL CLINIC INC	8767 MARYSVILLE ROAD	OREGON HOUSE	CA	95962	9166922050
553881	SISKIYOU MEDICAL GROUP DRLARGO	824 PINE STRRET	MOUNT SHASTA	CA	96067	9169265261

Source: CMS, 2008

Rural Health Clinics in California
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Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
553882	SANTA ROSA DEL VALLE MEDICAL GROUP, INC	1293 SIXTH STREET	COACHELLA	CA	92236	7603915151
553883	SISKIYOU MEDICAL GROUP DRPARKER	822 PINE STREET	MOUNT SHASTA	CA	96067	9169265261
553884	GONZALES MEDICAL GROUP INC	133 FOURTH STREET	GONZALES	CA	93926	8316753601
553885	AMERICAN DESERT MEDICAL CLINICS	6186 ADOBE ROAD	29 PALMS	CA	92277	7603618525
553886	STAR MEDICAL CLINIC	55585 29 PALMS HIGHWAY	YUCCA VALLEY	CA	92284	7602283366
553887	FIRST VALLEY MEDICAL GROUP	1535 NORTH CHINA LAKE BLVD SUITE A	RIDGECREST	CA	93555	6194461691
553888	BRIDGEVILLE HEALTH CLINIC	38717 KNEELAND ROAD	BRIDGEVILLE	CA	95526	7077773456
553889	PARADISE WALK IN MEDICAL CLINIC	7321 SKYWAY	PARADISE	CA	95969	9168768120
553890	WINTON MEDICAL CLINIC	6590 NORTH WINTON WAY	WINTON	CA	95388	2093588201
553891	BLOSS MEMORIAL DISTRICT HOSP PRIMARY	1691 THIRD STREET, SUITE 7	ATWATER	CA	95301	2093588201
553892	CASTLE MEDICAL CLINIC	3605 HOSPITAL ROAD, BLDG 1182	ATWATER	CA	95342	2093588201
553893	MIDDLETOWN MEDICAL CLINIC	21337 BUSH STREET	MIDDLETOWN	CA	95461	7079873311
553894	CAL CITY CLINIC	9300 NORTH LOOP	CALIF CITY	CA	93505	6193731256
553895	TULARE COMMUNITY HEALTH CLINIC	1101 CHERRY STREET	TULARE	CA	93274	2096854601
553896	BOB D PETERSON, MD	26617 STATE HIGHWAY 120	ESCALON	CA	95320	2098386015
553897	WEST HILLS MEDICAL GROUP, INC	155 S FIFTH ST #B	COALINGA	CA	93210	2099354282
553898	DINUBA RURAL HEALTH CENTER	420 EAST EL MONTE WAY	DINUBA	CA	93618	2095959500
553899	BORREGO MEDICAL CENTER	4343 YAQUI PASS RD	BORREGO SPRINGS	CA	92004	7607675051
553900	JAMES OOI, MD	320 SOLANO STREET	CORNING	CA	96021	9168243283
553901	MOUNTAIN HIGH MEDICAL CENTER	41340 BIG BEAR BLVD	BIG BEAR LAKE	CA	92315	9098662273
553902	HUGHSON MEDICAL OFFICE	2412 THIRD STREET	HUGHSON	CA	95326	2095587190
553903	COMMUNITY COMPREHENSIVE CARE P	2767 OLIVE HIGHWAY SUITE #5	OROVILLE	CA	95965	2092222222
553904	HAYFORK HEALTH CENTER	HIGHWAY 3, MAIN STREET	HAYFORK	CA	96041	5306285517
553905	PINE VALLEY FAMILY MEDICINE	28876 OLD HWY 80	PINE VALLEY	CA	91962	6194737696
553906	ARMONA FAMILY HEALTH CENTER	14054 FRONT STREET	ARMONA	CA	93202	2095836097
553907	KINGS RURAL HEALTH - HANNA	1310 HANNA AVENUE, SUITE 1	CORCORAN	CA	93212	2099925051
553908	COOMUNITY COMPREHENSIVE CARE W	900 ORO DAM BLVD	OROVILLE	CA	95965	5305344530
553909	FRONTIER VILLAGE FAMILY HEALTH CENTER, INC	645 ANTELOPE BLVD, SUITE 24	RED BLUFF	CA	96080	5305287650
553910	CLINICA DE SALUD DEL VALLE DE SALINAS	809 BROADWAY, SUITE A	KING CITY	CA	93930	8313855944
553911	OROSI FAMILY MEDICAL CENTER	12683 AVENUE 416	OROSI	CA	93647	5595284717
553912	KHUSAL MEHTA, MD RHC	430 VERMONT AVENUE	DINUBA	CA	93618	5595911060

Source: CMS, 2008

Rural Health Clinics in California
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Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
553913	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	1288 NORTH IRWIN STREET	HANFORD	CA	93230	5595847200
553914	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	1026 CHASE AVENUE	CORCORAN	CA	93212	2099928200
553915	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	2357 W TAHOE	CARUTHERS	CA	93609	5598674416
553916	COALINGA VALLEY HEALTH CLINICS INC-COALINGA	1145 PHELPS AVENUE, STE B	COALINGA	CA	93210	5599354374
553917	COMMUNITY COMPREHENSIVE CARE O	1611 FEATHER RIVER BLVD #5	OROVILLE	CA	95965	5308461400
553919	WINDWALKER RURAL HEALTH CLINIC	317 ALPINE STREET	AVENAL	CA	93204	5593864636
553920	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	1286 NORTH IRWIN STREET	HANFORD	CA	93230	5595847200
553921	PORTERVILLE HEALTH CARE CENTER	465 WEST PUTNAM AVENUE	PORTERVILLE	CA	93257	5597823900
553922	SEELY MEDICAL CORPORTATION, MC	433 LAWNDALE COURT	MCCLOUD	CA	96057	5309642246
553923	JOHN D ARTERBERRY, MD	56 669 29 PALMS HIGHWAY, SUITE D	YUCCA VALLEY	CA	92284	7603690414
553924	COTTONWOOD MEDICAL GROUP	20633 GAS POINT ROAD	COTTONWOOD	CA	96022	5303474867
553925	YOUSSEF B HADWEH, MD	1020 VENTURA BLVD	CHOWCHILLA	CA	93610	5596650275
553926	MARIAN COMMUNITY CLINICS GUADALUPE	4723 W MAIN ST STE H	GUADALUPE	CA	93434	8053432004
553927	COALINGA VALLEY HEALTH CLINICS, INC-HURON	36617 CENTRAL AVENUE,	HURON	CA	93234	5599459251
553928	DR NDULE MEDICAL PRACTICE	620 E STREET	OROVILLE	CA	95966	5307412600
553929	WESTSIDE MEDICAL GROUP	1107 O STREET	FIREBAUGH	CA	93622	5595699000
553930	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	337 KINGS STREET	AVENAL	CA	93204	5593865200
553931	CHUK NDULE MEDICAL CENTER	800 SPRUCE STREET	GRIDLEY	CA	95948	5308461400
553932	CORCORAN DISTRICT HOSPITAL HEALTH CENTER	1310 HANNA AVENUE, SUITE 3	CORCORAN	CA	93212	5599925051
553933	BAUTISTA RURAL MEDICAL CLINICS, INC	2570 JENSEN AVENUE, SUITE 106	SANGER	CA	93657	5598753428
553934	MCCLOUD HEALTHCARE CLINIC	116 WEST MINNESOTA AVENUE	MCCLOUD	CA	96057	5309642389
553935	OROSI RURAL HEALTH CLINIC	12572 AVENUE 416, SUITE B	OROSI	CA	93647	5595284779
553936	COLUSA INDIAN HEALTH CLINIC	3710 HIGHWAY 45	COLUSA	CA	95932	5304588231
553937	WOMENS AND CHILDREN HEALTHCARE ASSOC	57463 TWENTYNINE PALMS HWY, SUITE 2(	YUCCA VALLEY	CA	92284	7603650808
553938	SOLEDAD MEDICAL CLINIC	600 MAIN STREET	SOLEDAD	CA	93960	8316782462
553939	SAN JOAQUIN PRIME CARE MEDICAL CORP	682 EAST VISALIA ROAD	FARMERSVILLE	CA	93223	5595944564
553940	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	1274 N IRWIN STREET	HANFORD	CA	93230	5595822342
553941	FAMILY HEALTH CENTRE MEDICAL G	686 WEST LINE STREET	BISHOP	CA	93514	7608724311
553942	HARMONY HEALTH MEDICAL CLINIC	1908 NORTH BEALE ROAD, SUITE E	MARYSVILLE	CA	95901	5307436888
553943	RANCHOS FAMILY HEALTH SERVICES	11976 ROAD 37, AVENUE 12	MADERA	CA	93637	5596454191
553944	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	741 SUNSET AVENUE	COALINGA	CA	93210	5599350823

Source: CMS, 2008

Rural Health Clinics in California
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Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
553945	VALLEY FAMILY HEALTH CTR/MATERNAL & CHILD C	275 SOUTH MADERA AVENUE, SUITE 201	KERMAN	CA	93630	5598465240
553946	SELMA RURAL HEALTH CENTER	2057 HIGH STREET	SELMA	CA	93662	5598919100
553947	SAN JOAQUIN PRIME CARE MEDICAL CORP	826 EAST MANNING AVENUE	REEDLEY	CA	93654	5595922134
553948	SISKIYOU FAMILY HEALTHCARE	700 SOUTH MAIN STREET, SUITE 1	YREKA	CA	96097	5308420817
553949	WOMEN'S MEDICAL CLINIC	468 VERMONT AVENUE	DINUBA	CA	93618	5595916200
553950	SUTTER NORTH BROWNSVILLE FAMILY CENTER	16911 WILLOW GLEN ROAD	BROWNSVILLE	CA	95919	5306750466
553951	RAVI I KUMAR MD, INC/BEST HEALTHCARE CENTER	1001 VAN DORSTEN AVENUE	CORCORAN	CA	93212	5599922337
553952	CAMPUS FAMILY HEALTH MEDICAL CENTER	355 CAMPUS DRIVE, SUITE E	HANFORD	CA	93230	5595842721
553954	SHASTA DAM MEDICAL CLINIC	5145 SHASTA DAM BLVD	SHASTA LAKE	CA	96019	5302755421
553955	LASSEN MEDICAL GROUP-RED BLUFF	2450 SISTER MARY COLUMBA DRIVE	RED BLUFF	CA	96080	5305270414
553956	LASSEN MEDICAL GROUP-CORNING	702 SOLANO STREET	CORNING	CA	96021	5308249590
553957	LASSEN MEDICAL GROUP-COTTONWOOD	3435 MAIN STREET	COTTONWOOD	CA	96022	5303473418
553958	BURNEY HEALTH CENTER	20642 COMMERCE WAY	BURNEY	CA	96013	5303355457
553959	FALL RIVER VALLEY HEALTH CENTE	43563 HIGHWAY 299 EAST	FALL RIVER MILLS	CA	96028	5303366535
553960	CASCADE HEALTH CENTER	37394 CASCADE AVENUE	BURNEY	CA	96013	5303352954
553961	SARVAMITRA AWASTHI MEDICAL CLINIC	40657 ROAD 128	CUTLER	CA	93615	5595283860
553962	ORCHARD MEDICAL CENTER	555 SIXTH STREET	ORANGE COVE	CA	93646	5596267118
553963	DOWNTOWN EXPRESS MEDICAL GROUP	2456 BUHNE STREET	EUREKA	CA	95501	7074432293
553964	JAMES CORONA, MD	203 WALKER STREET, SUITE 2	ORLAND	CA	95963	5308656430
553965	MAGALIA-PINES FAMILY PRACTICE MEDICAL CLINIC	14662 SKYWAY	MAGALIA	CA	95954	5308731676
553966	WHEATLAND FAMILY HEALTH CENTER	411 FOURTH STREET	WHEATLAND	CA	95692	5306339398
553967	LUCERNE COMMUNITY CLINIC	6300 E HIGHWAY 20	LUCERNE	CA	95458	7072749299
553968	COLUSA INDIAN HEALTH CLINIC DBA ARBUCKLE ME	900 KING STREET	ARBUCKLE	CA	95912	5304763144
553969	TIPTON MEDICAL CLINIC	575 NORTH THOMPSON ROAD	TIPTON	CA	93272	5597624147
553972	FAIRCHILD MEDICAL GROUP, INC	475 BRUCE STREET, SUITE 500	YREKA	CA	96097	5308423507
553973	COVERED BRIDGE MEDICAL & COUNSELING SERVIC	2367 HARRISON AVENUE	EUREKA	CA	95501	7074424600
553974	LOS BANOS FAMILY CARE	285 MERCY SPRINGS, STE D	LOS BANOS	CA	93635	2098271440
553975	HURON MEDICAL GROUP	36617 CENTRAL AVE	HURON	CA	93234	2099459251
553976	CHOWCHILLA MEDICAL CENTER	285 HOSPITAL DRIVE	CHOWCHILLA	CA	93610	2096653768
553977	TEHACHAPI FAMILY HEALTH CENTER	115 WEST E STREET	TEHACHAPI	CA	93561	6618223241
553978	OAKDALE COMMUNITY HEALTH CENTER	1420 WEST H STREET	OAKDALE	CA	95361	2098481743

Source: CMS, 2008

Rural Health Clinics in California
2008

Provider Number	Facility Name	Street Address	City	State	Zip	Telephone
553979	TEHACHAPI FAMILY HEATH CENTER - MOJAVE	2041 BELSHAW STREET	MOJAVE	CA	93501	6618244511
553981	EXETER CLINIC,THE	215 CRESPI AVE	EXETER	CA	93221	5595927327
553982	FAMILY CARE CENTER	240 SPRUCE ST	GRIDLEY	CA	95948	9168465671
553983	CENTRAL VALLEY FAMILY HEALTH/HANFORD	1025 N DOUTY ST	HANFORD	CA	93230	5595832254
553984	SIERRA VIEW DIST HOSP COMM HLTH CLINIC	465 WEST PUTNAM AVENUE	PORTERVILLE	CA	93257	5597841110
553985	GRAEAGLE MEDICAL CLINIC RHC	7597 HIGHWAY 89	GRAEAGLE	CA	96103	9168361122
553986	HANFORD HEALTH CLINIC	1028 N DOUTY	HANFORD	CA	93230	2095844455
553989	SELMA COMMUNITY HEALTH CENTER	1041 ROSE AVE	SELMA	CA	93662	2098916660
553990	SHELTER COVE COMMUNITY CLINIC	9126 SHELTER VOCE ROAD	WHITETHORN	CA	95589	7079233925
553991	SOUTHERN HUMBOLDT COMMUNITY CLINIC	509 ELM ST	GARBERVILLE	CA	95542	7079233925
553992	LIVE OAK FAMILY CARE CENTER	2675 APRICOT STREET	LIVE OAK	CA	95953	9168465671
553994	SUTTER LAKESIDE FAMILY MEDICINE CLINIC	5176 HILL ROAD EAST	LAKEPORT	CA	95453	7072635651
553995	KELSEY CREEK CLINIC	4241 CHURCH ST	KELSEYVILLE	CA	95451	7072798813
553996	VERMEIL HOUSE MEDICAL CLINIC	913 WASHINGTON	CALISTOGA	CA	94515	7079426382
553997	SOLEDAD MEDICAL CLINIC	600 MAIN ST	SOLEDAD	CA	93960	4086782462
553998	MEMORIAL HOSP LOS BANOS RURAL HLTH CLI	400 WEST I STREET, SUITE C	LOS BANOS	CA	93635	2098260591

Source: CMS, 2008

Critical Access Hospital Program: Designation Protocol

A Critical Access Hospital (CAH) is a hospital designation made possible by the Medicare Rural Hospital Flexibility Program established by the federal government in the Balanced Budget Act of 1997 (Public Law 105-33), and recently updated through provisions contained in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. A CAH receives increases revenues through cost based reimbursement from Medicare and greater flexibility in delivery of services. Steps outlining the CAH certification process, which can take upwards of six months to complete, are described below.

The acronyms asterisked below identify the following organizations that administer different parts of California's Medicare Rural Hospital Flexibility Program:

- CalSORH, the California State Office of Rural Health
- DHS L&C, Department of Health Services Licensing & Certification
- CHA/RHC, the California Hospital Association's Rural Healthcare Center
- CMS, the federal Centers for Medicare and Medicaid Services

Step to CAH Certification:

1. Hospital submits a letter of intent for Participation in the CAH Program to CalSHORH.
2. Hospital downloads a State Application for Participation in the Medicare Rural Hospital Flexibility Program as a CAH from CalSORH's website: www.prh.dhs.ca.gov.
3. CalSORH'S CAH program manager schedules and conducts an informal hospital site visit, and meets with staff and governing board members to discuss the CAH program requirements and benefits.
4. Hospital checking NO to Question 2 under Part A of the CAH application (federal mileage criteria) must submit a letter with the application package to CalSORH requesting consideration as a State designated "Necessary Provider".
5. Hospital completes the CAH application (technical assistance can be requested from CalSORH's CAH program manager to complete the application).
6. Hospital submits and mails completed CAH application package to CalSORH at DHS, State Office of Rural Health, 1615 Capitol Avenue, MS 8500, Suite 73.460; P.O. Box 997413, Sacramento, CA 95899-7413.
7. CalSORH reviews CAH application for completeness and notifies hospital if further supporting documentation is required.
8. CalSORH processes the hospital's request for "Necessary Provider" designation, if applicable.
9. CalSORH notifies *CHA/RHC of the need to conduct a financial feasibility analysis of the applicant hospital.
10. A CHA/RHC contractor conducts the financial feasibility analysis.
11. Hospital reviews the financial results and determines whether or not to continue with CAH designation process.

12. Hospital sends an email to CalSORH either asking to proceed with the CAH designation process or withdrawing the CAH application.
13. If appropriate, CalSORH sends written notification to *CMS and *DHS L&C of the State's designation of the hospital as a "Necessary Provider".
14. CalSORH submits the hospital's completed application package to DHS L&C which will conduct the formal CAH certification survey.
15. Hospital can request technical assistance for CalSORH and CHA/RHC to prepare for CAH certification survey.
16. Hospital contacts JACHO/DHS to schedule a survey.
17. JACHO/DHS L&C conducts CAH certification survey.
18. DHS L&C notifies hospital applicant and CalSORH in writing of CAH survey results.
19. CMS notifies the hospital and DHS L&C of the new hospital provider number
20. CalSORH and CHA/RHC provide ongoing technical assistance for CAHs if requested.

Licensed Clinics

The Office of Statewide Health Planning and Development is responsible for writing regulations pertaining to licensed clinics. These regulations are identified in the California Building Standards Code as "OSHPD 3." OSHPD 3 requirements for clinics shall only be applied to clinics that are licensed pursuant to Health and Safety Code (H&S) Section 1200 (which includes primary care clinics and specialty clinics) or outpatient services of a hospital licensed pursuant to H&S 1250.

The following documents are intended to assist designers, building officials and clinic operators in applying OSHPD 3 requirements, and determining which jurisdiction has authority over the plan review, certification and construction inspection of clinic facilities

OSHPD ID	Facility Name	City
194083	20TH STREET SURGERY CENTER, LLC	SANTA MONICA
494075	4TH STREET LASER AND SURGERY CENTER	SANTA ROSA
197005	90210 SURGERY MEDICAL CENTER, LLC	BEVERLY HILLS
334495	AARONSON PLASTIC SURGERY CENTER	PALM SPRINGS
364309	ADVANCED AMBULATORY SURGERY CENTER, LP	REDLANDS
196505	ADVANCED DIAGNOSTICS AND SURGICAL CENTER	ALHAMBRA
244032	ADVANCED ENDOSCOPY CENTER	MERCED
274063	ADVANCED MEDICAL SURGERY CENTER	SALINAS
334504	ADVANCED PAIN MANAGEMENT	RANCHO MIRAGE
105009	ADVANCED SURGERY CENTER	FRESNO
434163	ADVANCED SURGERY CENTER	SAN JOSE
304093	AESTHETICARE OUTPATIENT SURGERY CENTER	SAN JUAN CAPISTRANO
196217	AIRPORT ENDOSCOPY CENTER	LOS ANGELES
196194	ALAMEDA SURGERY CENTER	BURBANK
196247	ALLCARE AMBULATORY SURGERY CENTER	VAN NUYS
154035	ALLIANCE SURGERY CENTER	BAKERSFIELD
034003	AMADOR SURGERY CENTER	JACKSON
374139	AMBULATORY CARE SURGERY CENTER, INC.	SAN DIGEO
394061	AMBULATORY SURGERY CENTER OF STOCKTON	STOCKTON
194175	AMBULATORY SURGICAL CENTER OF SOUTHERN CALIFORNIA	MONTEREY PARK
394024	AMBULATORY SURGICAL CENTER OF THE ZEITER EYE	STOCKTON
194300	ANTELOPE VALLEY SURGERY CENTER	LANCASTER
454039	APOGEE OUT PATIENT SURGERY CENTER	REDDING
334106	ARLINGTON PODIATRY SURGERY CENTER	RIVERSIDE
564012	ASPEN OUTPATIENT CENTER	SIMI VALLEY
454026	ASSOCIATES OUTPATIENT SURGERY CENTER	REDDING
414084	ATHERTON ENDOSCOPY CENTER	ATHERTON
414015	ATHERTON PLASTIC SURGERY CENTER	ATHERTON
334516	AURORA SURGERY CENTER	PALM DESERT
154074	BAKERSFIELD ENDOSCOPY CENTER	BAKERSFIELD
434046	BASCOM SURGERY CENTER	CAMPBELL
434170	BAY AREA SURGICAL GROUP	SANTA CLARA
014174	BAY SURGERY CENTER	OAKLAND
196821	BEACH DISTRICT SURGERY CENTER, L.P.	REDONDO BEACH
196561	BEDFORD AMBULATORY SURGERY CENTER	BEVERLY HILLS
196178	BEDFORD OUTPATIENT SURGERY CENTER	BEVERLY HILLS
364263	BENEFIT SURGERY CENTER	RANCHO CUCAMONGA
194996	BEVERLY HILLS ADVANCED SURGERY INSTITUTE	BEVERLY HILLS
194794	BEVERLY HILLS CENTER FOR SPECIAL SURGERY, THE	LOS ANGELES

OSHPD ID	Facility Name	City
196049	BEVERLY HILLS CTR FOR ARTHROSCOPIC AND OUTPT SURGERY	LOS ANGELES
196117	BEVERLY HILLS DOCTORS SURGERY CENTER	BEVERLY HILLS
194865	BEVERLY HILLS SUNSET SURGERY CENTER, INC	LOS ANGELES
194999	BRENTWOOD AMBULATORY SURGICAL MEDICAL CENTER	LOS ANGELES
074127	BRENTWOOD SURGERY CENTER - BRENTWOOD	BRENTWOOD
194682	BRENTWOOD SURGERY CENTER - LOS ANGELES	LOS ANGELES
196193	BRIGHTON SURGICAL CENTER, INC.	BEVERLY HILLS
334593	BROCKTON SURGERY CENTER	RIVERSIDE
074056	CALIFORNIA EYE CLINIC	ANTIOCH
564119	CALIFORNIA MINIMALLY INVASIVE SURGICAL CENTER, INC	NEWBURY PARK
304289	CALIFORNIA SPECIALTY SURGERY CENTER	MISSION VIEJO
194602	CAMDEN SURGERY CENTER OF BEVERLY HILLS	BEVERLY HILLS
434115	CAMINO MEDICAL GROUP, INC.-ENDOSCOPY UNIT	SUNNYVALE
414009	CAMPUS SURGERY CENTER LP	DALY CITY
074111	CANYON PINOLE SURGERY CENTER	PINOLE
344135	CAPITOL CITY SURGERY CENTER	SACRAMENTO
196679	CASA COLINA SURGERY CENTER	POMONA
244030	CASTLE SURGICENTER, PARTNERSHIP	ATWATER
154098	CBCC PAIN MEDICINE AND SURGERY CENTER, INC.	BAKERSFIELD
374087	CENTER FOR ENDOSCOPY	OCEANSIDE
195011	CENTER FOR ORTHOPEDIC SURGERY	VAN NUYS
196046	CENTER FOR OUTPATIENT SURGERY	WHITTIER
196612	CENTINELA VALLEY ENDOSCOPY CENTER	INGLEWOOD
105019	CENTRAL CALIFORNIA ENDOSCOPY CENTER	FRESNO
444015	CENTRAL COAST ENDOSCOPY CENTER	FREEDOM
444019	CENTRAL COAST SURGERY CENTER	FREEDOM
364086	CENTRE FOR PLASTIC SURGERY, THE	SAN BERNARDINO
374074	CENTRE FOR SURGERY OF ENCINITAS	ENCINITAS
564037	CHANNEL ISLANDS SURGICENTER	OXNARD
196624	CHEVY CHASE AMBULATORY CENTER	GLENDALE
044153	CHICO SURGERY CENTER, LP	CHICO
374243	COAST SURGERY CENTER	SAN DIEGO
196106	COAST SURGERY CENTER OF SOUTH BAY	TORRANCE
404053	COASTAL SURGICAL INSTITUTE	PISMO BEACH
195035	COLIMA ENDOSCOPY CENTER	ROWLAND HEIGHTS
194977	COLUMBIA WEST HILLS SURGICAL CENTER	WEST HILLS
105036	COMMUNITY OUTPATIENT SURGERY CENTER	FRESNO
194781	COMPREHENSIVE OUTPATIENT SURGERY CENTER	BEVERLY HILLS
105017	COMPREHENSIVE PAIN MANAGEMENT CENTER	FRESNO

454040	COURT STREET SURGERY CENTER	REDDING
544072	COURTYARD SURGERY PAVILION	VISALIA
304225	CROWN VALLEY SURGICENTER	MISSION VIEJO
424050	CYPRESS AMBULATORY SURGERY CENTER	SANTA MARIA
444003	CYPRESS OUTPATIENT SURGICAL CENTER, INC.	SANTA CRUZ
544027	CYPRESS SURGERY CENTER	VISALIA
074041	DANVILLE AMBULATORY SURGERY CENTER	DANVILLE
574016	DAVIS SURGERY CENTER	DAVIS
334538	DE ANZA SURGERY CENTER	RIVERSIDE
374276	DEL MAR SURGERY CENTER	SAN DIEGO
194815	DEL REY SURGERY CENTER	MARINA DEL REY
564115	DERMATOLOGY AND REJUVENATION MEDICAL CENTER	THOUSAND OAKS
334507	DESERT ORTHOPEDIC SURGERY CENTER	RANCHO MIRAGE
014180	DIALYSIS ACCESS CENTER, INC.	OAKLAND
196568	DIAMOND BAR SURGERY CENTER	DIAMOND BAR
414085	DIGESTIVE DIAGNOSTIC CENTER, INC.	DALY CITY
304203	DIGESTIVE DISEASE CENTER	LAGUNA HILLS
304413	DOCTORS SURGERY CENTER	FOUNTAIN VALLEY
194834	DOWNEY SURGERY CENTER	DOWNEY
104050	E. N. T. FACIAL SURGERY CENTER	FRESNO
OSHPD ID	**Facility Name**	**City**
014160	EAST BAY ENDOSCOPY CENTER, L.P.	EMERYVILLE
014186	EAST BAY ENDOSURGERY CENTER	OAKLAND
014015	EAST BAY MEDICAL SURGICAL CENTER, L.P.	CASTRO VALLEY
434045	EL CAMINO SURGERY CENTER	MOUNTAIN VIEW
094021	EL DORADO SURGERY CENTER	PLACERVILLE
334440	EL MIRADOR SURGICAL CENTER	PALM SPRINGS
374309	ELITE SURGICAL CENTERS DEL MAR	SAN DIEGO
154107	EMPIRE SURGERY CENTER PARTNERS	BAKERSFIELD
196094	ENCINO PLAZA SURGICAL CENTER	ENCINO
196809	ENCINO SURGICAL MEDICAL CENTER	ENCINO
196310	ENDOSCOPY CENTER AT SKYPARK	TORRANCE
374181	ENDOSCOPY CENTER OF CHULA VISTA	CHULA VISTA
214032	ENDOSCOPY CENTER OF MARIN	GREENBRAE
434150	ENDOSCOPY CENTER OF SAN JOSE	SAN JOSE
196554	ENDOSCOPY CENTER OF SANTA MONICA	LOS ANGELES
494087	ENDOSCOPY CENTER OF SANTA ROSA	SANTA ROSA
434148	ENDOSCOPY CENTER OF SILICON VALLEY	SAN JOSE
194285	ENDOSCOPY CENTER OF SOUTHERN CALIFORNIA	SANTA MONICA
404021	ENDOSCOPY CENTER OF THE CENTRAL COAST, THE	SAN LUIS OBISPO
334535	ENDOSCOPY CENTER OF THE INLAND EMPIRE	MURRIETA
194264	ENDOSCOPY CENTER OF THE SOUTH BAY, THE	TORRANCE
514009	ENDOSCOPY CENTER, THE	YUBA CITY
424041	ENDOSCOPY SURGERY CENTER OF SANTA MARIA	SANTA MARIA

374399	EUCLID ENDOSCOPY CENTER, LP	SAN DIEGO
074030	EYE CENTER OF NORTHERN CALIFORNIA SURGICENTER	EL CERRITO
044018	EYE LIFE INSTITUTE	PARADISE
014159	EYE MD LASER AND SURGERY CENTER	OAKLAND
344023	EYE SURGERY CENTER OF NORTHERN CALIFORNIA, THE	CITRUS HEIGHTS
384199	EYE SURGERY CENTER OF SAN FRANCISCO, L.P.	SAN FRANCISCO
374159	EYE SURGERY CENTER OF SOUTHERN CALIFORNIA, INC	VISTA
344130	FOLSOM SIERRA ENDOSCOPY CENTER L.P.	FOLSOM
344129	FOLSOM SURGERY CENTER	FOLSOM
364104	FOOTHILL AMBULATORY SURGERY CENTER	UPLAND
304410	FOOTHILL RANCH SURGERY AND MEDICAL CTR., INC.	FOOTHILL RANCH
196552	FOOTHILL SURGERY CENTER	ARCADIA
434024	FOREST SURGERY CENTER	SAN JOSE
344015	FORT SUTTER SURGERY CENTER	SACRAMENTO
196195	FOUR SEASONS SURGERY CENTER OF ENCINO	ENCINO
304287	FOUR SEASONS SURGERY CENTERS OF ANAHEIM	ANAHEIM
364282	FOUR SEASONS SURGERY CENTERS OF ONTARIO	ONTARIO
196047	FREEDOM VISION CENTERS MEDICAL ASSOCIATES	ENCINO
014125	FREMONT AMBULATORY SURGERY CENTER	FREMONT
014165	FREMONT SURGERY CENTER-NORTH	FREMONT
105047	FRESNO DENTAL SURGERY CENTER	FRESNO
105006	FRESNO ENDOSCOPY CENTER	FRESNO
334480	FSCI, INC., SURGERY CENTER	PALM SPRINGS
304346	FULLERTON SURGICAL CENTER	FULLERTON
404039	GALILEO SURGERY CENTER	SAN LUIS OBISPO
304141	GASTRODIAGNOSTIC, A MEDICAL GROUP	ORANGE
OSHPD ID	**Facility Name**	**City**
105033	GASTROENTEROLOGY AND LIVER DISEASE MEDICAL CTR., INC.	FRESNO
197065	GLENDALE ENDOSCOPY CENTER, LLC	GLENDALE
194569	GLENDALE EYE SURGERY CENTER	GLENDALE
196553	GLENDORA DIGESTIVE DISEASE INSTITUTE	GLENDORA
197032	GLENDORA SURGERY CENTER	GLENDORA
334092	GLENWOOD SURGICAL CENTER, L P	RIVERSIDE
384195	GOLDEN GATE ENDOSCOPY CENTER, L.P.	SAN FRANCISCO
334062	GOLDEN TRIANGLE SURGI-CENTER	MURRIETA
294017	GRASS VALLEY SURGERY CENTER	GRASS VALLEY
014193	GREATER BAY ENDOSCOPY CENTER	HAYWARD
194595	GREATER LONG BEACH ENDOSCOPY CENTER	LONG BEACH
341088	GREATER SACRAMENTO SURGERY CENTER	SACRAMENTO
214039	GREENBRAE SURGERY CENTER	GREENBRAE
371705	GROSSMONT SURGERY CENTER	LA MESA
404027	HALCYON LASER AND SURGERY CENTER, INC	ARROYO GRANDE

364278	HALLMARK SURGICAL CENTER	SAN BERNARDINO
194329	HALLMARK SURGICAL CENTER OF NORTHRIDGE	NORTHRIDGE
164021	HANFORD SURGERY CENTER	HANFORD
234027	HARRY B. MATOSSIAN, M.D. ENDOSCOPY CENTER	UKIAH
196051	HARVARD SURGERY CENTER	LOS ANGELES
154140	HEALING ARTS SURGERY CENTER	BAKERSFIELD
190969	HEALTH SOUTH ARCADIA OUTPATIENT SURGERY CENTER	ARCADIA
374108	HEALTHSOUTH NORTH COAST SURGERY CENTER	OCEANSIDE
374147	HEALTHSOUTH RANCHO BERNARDO SURGERY CENTER	SAN DIEGO
404006	HEALTHSOUTH SURGERY CENTER	SAN LUIS OBISPO
494003	HEALTHSOUTH SURGERY CENTER OF SANTA ROSA	SANTA ROSA
334562	HEMET ENDOSCOPY CENTER	HEMET
334085	HEMET HEALTHCARE SURGICENTER	HEMET
334007	HEMET URO-ENDO SURGICENTER, INC.	HEMET
364139	HI DESERT SURGERY CENTER	APPLE VALLEY
364095	HIGH DESERT ENDOSCOPY	APPLE VALLEY
196511	HIGH DESERT HEALTH SYSTEM AMBULATORY SURGICAL CTR.	LANCASTER
334436	HOPE SQUARE SURGICAL CENTER	RANCHO MIRAGE
194069	HUNTINGTON OUTPATIENT SURGERY CENTER	PASADENA
304332	HUNTINGTON SURGERY CENTER	HUNTINGTON BEACH
154091	INDIAN WELLS VALLEY SURGERY CENTER	RIDGECREST
334578	INDIO SURGERY CENTER INC.	INDIO
364246	INLAND EMPIRE OUTPATIENT SURGERY CENTER, INC.	SAN BERNARDINO
334076	INLAND SURGERY CENTER	HEMET
364008	INLAND SURGERY CENTER	REDLANDS
334539	INLAND SURGERY CENTER MURRIETA	MURRIETA
244040	INTERVENTIONAL PAIN CENTER OF MERCED	MERCED
304345	IRVINE ENDOSCOPY AND SURGICAL INSTITUTE	IRVINE
304197	IRVINE MULTI-SPECIALITY SURGICAL CARE	IRVINE
194997	JIN H. SUH, M.D., MEDICAL OFFICE	LOS ANGELES
196303	JOURNEY LITE OF THOUSAND OAKS	THOUSAND OAKS
196069	KERLAN-JOBE SURGERY CENTER	LOS ANGELES
164017	KINGS EYE CENTER MEDICAL GROUP, INC.	HANFORD
374137	LA JOLLA ENDOSCOPY CENTER	LA JOLLA
OSHPD ID	**Facility Name**	**City**
374288	LA JOLLA ORTHOPEDIC SURGERY CENTER	LA JOLLA
196239	LA PEER SURGERY CENTER LLC	BEVERLY HILLS
334499	LA QUINTA SURGERY CENTER	LA QUINTA
304130	LA VETA SURGICAL CTR., AN AFFILIATE OF HEALTHSOUTH	ORANGE
304313	LAGUNA HILLS SURGERY CENTER	LAGUNA WOODS

274058	LAS VENTANAS SURGERY CENTER	SALINAS
074068	LASER SURGERY CENTER, LTD	WALNUT CREEK
184004	LASSEN SURGERY CENTER	SUSANVILLE
394004	LODI OUTPATIENT SURGICAL CENTER	LODI
364023	LOMA LINDA AMBULATORY SURGICAL CENTER	LOMA LINDA
304315	LOS ALAMITOS SURGERY CENTER	LOS ALAMITOS
434151	LOS ALTOS SURGERY CENTER	LOS ALTOS
196045	LOS ANGELES ENDOSCOPY CENTER	LOS ANGELES
196071	LOS ANGELES SURGICAL CENTER	LOS ANGELES
434003	LOS GATOS SURGICAL CENTER	LOS GATOS
564027	LOS ROBLES SURGICENTER	THOUSAND OAKS
194286	M/S SURGERY CENTER	LYNWOOD
204021	MADERA AMBULATORY ENDOSCOPY CENTER	MADERA
204006	MADERA SURGERY CENTER	MADERA
194978	MADISON PARK SURGERY AND LASER CENTER	TORRANCE
334129	MAGNOLIA PLASTIC SURGERY CENTER	RIVERSIDE
304279	MAGNOLIA SURGERY CENTER	WESTMINSTER
304298	MAIN STREET SPECIALTY SURGERY CENTER, LP	ORANGE
214022	MARIN OPHTHALMIC AMBULATORY SURGI CLINIC	SAN RAFAEL
214036	MARIN SPECIALTY SURGERY CENTER	GREENBRAE
344036	MARTEL EYE INSTITUTE	RANCHO CORDOVA
502389	MCHENRY SURGERY CENTER PARTNERS, L.P.	MODESTO
544007	MEDICAL ARTS AMBULATORY SURGERY CENTER	VISALIA
196514	MED-LASER SURGICAL CENTER	MONTEBELLO
244015	MERCED AMBULATORY ENDOSCOPY CENTER	MERCED
454047	MERCY SURGERY CENTER	REDDING
304219	MESA SURGICENTER	FULLERTON
344118	MICHAEL J. FAZIO, MD. SURGERY CENTER	SACRAMENTO
414063	MID-PENINSULA ENDOSCOPY CENTER	SAN MATEO
196058	MID-WILSHIRE SURGERY CENTER	LOS ANGELES
304286	MILE SQUARE SURGERY CENTER, INC.	FOUNTAIN VALLEY
544047	MILL CREEK AMBULATORY SURGERY CENTER	VISALIA
154106	MILLENNIUM SURGERY CENTER, INC.	BAKERSFIELD
304247	MIMG ENDOSCOPY CENTER	MISSION VIEJO
196072	MIRACLE MILE OUTPATIENT SURGERY CENTER	LOS ANGELES
334529	MIRAGE ENDOSCOPY CENTER L.P.	RANCHO MIRAGE
304041	MISSION SURGERY CENTER	MISSION VIEJO
374331	MISSION VALLEY HEIGHTS SURGERY CENTER	SAN DIEGO
014038	MISSION VALLEY SURGERY CENTRE	FREMONT
504022	MODESTO SURGERY CENTER, INC.	MODESTO
194276	MONTEBELLO SURGERY CENTER, THE	MONTEBELLO
274061	MONTEREY BAY ENDOSCOPY CENTER	MONTEREY
274050	MONTEREY DOCTORS SURGERY CENTER	MONTEREY
196516	MONTEREY PARK OUTPATIENT SURGERY CENTER	MONTEREY PARK

OSHPD ID	Facility Name	City
274033	MONTEREY PENINSULA SURGERY CENTER	MONTEREY
274073	MONTEREY PENINSULA SURGERY CENTER RYAN RANCH	MONTEREY
434147	MONTPELIER AMBULATORY SURGICAL CENTER	SAN JOSE
074121	MOUNT DIABLO SURGERY CENTER	CONCORD
364140	MOUNTAIN VIEW SURGERY CENTER AND MEDICAL CLINIC	REDLANDS
284005	NAPA SURGERY CENTER, LLC	NAPA
544071	NATRAJ SURGERY CENTER, INC.	PORTERVILLE
304166	NEWPORT BEACH ORANGE COAST ENDOSCOPY CENTER	NEWPORT BEACH
304110	NEWPORT BEACH SURGERY CENTER	NEWPORT BEACH
304403	NEWPORT CENTER SURGICAL	NEWPORT BEACH
304264	NEWPORT COAST SURGERY CENTER, L.P.	NEWPORT BEACH
304342	NEWPORT PLAZA SURGICAL CENTER	COSTA MESA
544066	NOBLE SURGERY CENTER	VISALIA
304083	NORTH ANAHEIM SURGICENTER	ANAHEIM
494055	NORTH BAY EYE ASSOCIATES, ASC	SANTA ROSA
105016	NORTH POINT SURGERY CENTER, INC.	FRESNO
044158	NORTH VALLEY ENDOSCOPY CENTER	CHICO
434171	NORTHERN CALIFORNIA KIDNEY STONE CENTER	LOS GATOS
504047	NORTHERN CALIFORNIA SURGERY CENTER	TURLOCK
214038	NOVATO ENDOSCOPY CENTER, LLC	NAVATO
404045	OAK PARK SURGERY CENTER	ARROYO GRANDE
196664	OAK TREE ASC	PASADENA
334520	OAKS SURGERY CENTER, THE	MURRIETA
374233	OASIS HEALTHSOUTH SURGERY CENTER	SAN DIEGO
014206	OMNI SURGI CENTER, LP	FREMONT
014080	OPTIMA OPHTHALMIC MEDICAL ASSOCIATES, INC.	HAYWARD
304174	ORANGE CO INSTITUTE OF GASTROENTEROLOGY AND ENDOSCOPY	MISSION VIEJO
304300	ORANGE COAST SURGERY CENTER	ANAHEIM
304379	ORTHOPEDIC SURGERY CENTER OF ORANGE COUNTY, LLC	NEWPORT BEACH
374383	OTAY LAKES SURGERY CENTER, LLC	CHULA VISTA
301540	OUT-PATIENT SURGERY CENTER	HUNTINGTON BEACH
197008	PACIFIC AMBULATORY SURGERY CENTER	ALHAMBRA
196082	PACIFIC COAST SURGICAL CENTER	TORRANCE
154095	PACIFIC COAST SURGICAL CENTER NO.7	DELANO
196309	PACIFIC ENDO-SURGICAL CENTER	TORRANCE
364125	PACIFIC EYE INSTITUTE	UPLAND
304310	PACIFIC GASTROENTEROLOGY ENDOSCOPY CENTER	MISSION VIEJO
384170	PACIFIC HEIGHTS SURGERY CENTER	SAN FRANCISCO
304082	PACIFIC HILLS SURGERY CENTER, INC.	LAGUNA HILLS

564127	PACIFIC SURGERY CENTER OF VENTURA	VENTURA
374264	PACIFIC SURGICAL INSTITUTE OF PAIN MANAGEMENT	SAN DIEGO
194275	PACIFIC SURGICENTER INC.	SANTA MONICA
344128	PAIN DIAGNOSTIC AND TREATMENT CENTER, L.P.	SACRAMENTO
196200	PALMDALE - LANCASTER SURGERY CENTER	LANCASTER
434191	PALO ALTO MED. FDN. - CAMINO DIVISION SURGICENTER	MOUNTAIN VIEW
194546	PALOS VERDES AMBULATORY SURGERY MEDICAL CENTER,INC	TORRANCE
196053	PARKSIDE SURGERY INSTITUTE	SANTA MONICA
374283	PARKWAY ENDOSCOPY CENTER	ESCONDIDO
196165	PASADENA AMBULATORY SURGERY CENTER	PASADENA
OSHPD ID	**Facility Name**	**City**
196320	PASADENA ENDOSCOPY CENTER	PASADENA
196054	PASADENA LASER AND SURGERY CENTER	PASADENA
196204	PASADENA SURGERY CENTER	PASADENA
434169	PENINSULA EYE SURGERY CENTER	MOUNTAIN VIEW
414101	PENINSULA PROCEDURE CENTER, LP	REDWOOD CITY
494041	PETALUMA SURGICENTER	PETALUMA
154012	PHYSICIANS PLAZA SURGICAL CENTER	BAKERSFIELD
364315	PHYSICIAN'S SURGERY CENTER	VICTORVILLE
014102	PLASTIC AND RECONSTRUCTIVE SURGERY CENTER	PLEASANTON
434023	PLASTIC SURGERY CENTER	PALO ALTO
342259	PLASTIC SURGERY CENTER MEDICAL GROUP, INC, THE	SACRAMENTO
424060	PLAZA SURGERY CENTER, L.P.	SANTA MARIA
564047	PLAZA SURGICAL CENTER, INC.	VENTURA
105039	PLAZA SURGICAL CENTER, LP	FRESNO
014184	PLEASANTON SURGERY CENTER	PLEASANTON
334081	PODIATRIC SURGERY CENTER	HEMET
404047	POSADA AMBULATORY SURGERY CENTER, L.P.	TEMPLETON
384168	POST STREET SURGERY CENTER, LLC	SAN FRANCISCO
374314	POWAY SURGERY CENTER LP	POWAY
364253	PREMIER OUTPATIENT SURGERY CENTER, INC.	COLTON
074100	PREMIER SURGERY CENTER	CONCORD
424045	PREMIER SURGERY CENTER OF SANTA BARBARA	SANTA BARBARA
424065	PREMIER SURGERY CENTER OF SANTA MARIA	SANTA MARIA
374077	PREMIERE SURGERY CENTER, INC	ESCONDIDO
384012	PRESIDIO SURGERY CENTER	SAN FRANCISCO
304291	PROCEDURE CENTER OF IRVINE	IRVINE
344134	PROCEDURE CENTER OF SOUTH SACRAMENTO	SACRAMENTO
014219	PROCEDURE SUITES, FREMONT CENTER	FREMONT
504030	PUEBLO NUEVO AESTHETIC AND RECONSTRUCTIVE SURGERY	MODESTO
304412	REAGAN STREET SURGERY CENTER	LOS ALAMITOS
524007	RED BLUFF SURGERY CENTER, INC.	RED BLUFF

454031	REDDING ENDOSCOPY CENTER	REDDING
454042	REDDING SURGERY CENTER, LP	REDDING
364122	REDLANDS DENTAL SURGERY CENTER	REDLANDS
494103	REDWOOD EMPIRE SURGERY CENTER	WINDSOR
105032	REGIONAL HAND CENTER OF CENTRAL CALIFORNIA	FRESNO
196171	REGIONAL VALLEY SURGERY CENTER	LANCASTER
105060	RENAISSANCE SURGERY CENTER	FRESNO
334556	RENAISSANCE SURGERY CENTER OF EL PASEO	PALM DESERT
334044	RIVERSIDE EYE, EAR, NOSE AND THROAT INST. SURG. CTR.	RIVERSIDE
334512	RIVERSIDE MEDICAL CLINIC SURGICAL CENTER	RIVERSIDE
454032	RIVERSIDE SURGERY CENTER, INC.	REDDING
105057	RIVERVIEW AMBULATORY SURGICAL CENTER	FRESNO
314031	ROSEVILLE SURGERY CENTER	ROSEVILLE
196084	S AND B SURGERY CENTER	BEVERLY HILLS
196336	S AND B SURGERY CENTER II	BEVERLY HILLS
344097	SACRAMENTO EYE SURGICENTER	SACRAMENTO
344005	SACRAMENTO MIDTOWN ENDOSCOPY CENTER	SACRAMENTO
304109	SADDLEBACK EYE CENTER	LAGUNA HILLS
OSHPD ID	**Facility Name**	**City**
304064	SADDLEBACK VALLEY OUTPATIENT SURGERY	LAGUNA HILLS
504055	SALIDA SURGERY CENTER	SALIDA
274026	SALINAS SURGERY CENTER	SALINAS
434173	SAMARITAN ENDOSCOPY CENTER	LOS GATOS
364247	SAN ANTONIO AMBULATORY SURGICAL CENTER, INC.	UPLAND
374389	SAN DIEGO CENTER FOR REPRODUCTIVE SURGERY	SAN DIEGO
374149	SAN DIEGO ENDOSCOPY CENTER, A PARTNERSHIP	SAN DIEGO
370838	SAN DIEGO OUTPATIENT SURGICAL CENTER	SAN DIEGO
194005	SAN FERNANDO VALLEY SURGERY CENTER	MISSION HILLS
384171	SAN FRANCISCO ENDOSCOPY CENTER, LLC	SAN FRANCISCO
384172	SAN FRANCISCO SURGERY CENTER	SAN FRANCISCO
196623	SAN GABRIEL AMBULATORY SURGERY CENTER	SAN GABRIEL
194152	SAN GABRIEL VALLEY SURGICAL CENTER	WEST COVINA
394023	SAN JOAQUIN LASER AND SURGERY CENTER	STOCKTON
434112	SAN JOSE MEDICAL GROUP ENDOSCOPY SUITE	SAN JOSE
014035	SAN LEANDRO SURGERY CENTER	SAN LEANDRO
074099	SAN RAMON ENDOSCOPY CENTER, INC.	SAN RAMON
074107	SAN RAMON SURGERY CENTER	SAN RAMON
404022	SANI EYE SURGERY CENTER	TEMPLETON
304292	SANTA ANA OUTPATIENT SURGERY CENTER, L.P.	SANTA ANA
424061	SANTA BARBARA ENDOSCOPY CENTER, LLC	SANTA BARBARA
424051	SANTA BARBARA SURGICAL CENTER, L.P.	SANTA BARBARA
196221	SANTA CLARITA SURGERY CTR FOR	VALENCIA

	ADVANCED PAIN MGMNT	
441238	SANTA CRUZ SURGERY CENTER	SANTA CRUZ
424044	SANTA MARIA AMBULATORY SURGERY AND LASER CENTER INC.	SANTA MARIA
424057	SANTA MARIA DIGESTIVE DIAGNOSTIC CENTER	SANTA MARIA
194776	SANTA MONICA SURGERY AND LASER CENTER	SANTA MONICA
564118	SAXON SURGICAL CENTER, INC.	THOUSAND OAKS
374407	SCRIPPS ENCINITAS SURGERY CENTER	ENCINITAS
374339	SCRIPPS MERCY SURGERY PAVILION	SAN DIEGO
494006	SEBASTOPOL AMBULATORY SURGERY CENTER	SEBASTOPOL
334550	SEDONA SURGICAL CENTER, INC.	INDIO
074091	SEQUOIA SURGICAL PAVILION	WALNUT CREEK
196287	SERRA CLINIC SURGERY CENTER	SUN VALLEY
424069	SHEPARD EYE CENTER MEDICAL GROUP	SANTA MARIA
196174	SHERMAN OAKS SURGERY CENTER	SHERMAN OAKS
104039	SIERRA SURGERY CENTER	FRESNO
544057	SIERRA AMBULATORY SURGERY CENTER, A MEDICAL CORP.	VISALIA
294018	SIERRA AMBULATORY SURGERY CENTER, LLC	GRASS VALLEY
294013	SIERRA ENDOSCOPY CENTER, INC.	GRASS VALLEY
074014	SIERRA SURGI-CENTER	WALNUT CREEK
404024	SIERRA VISTA MEDICAL PAVILION AMBULATORY SURGERY	SAN LUIS OBISPO
434135	SILICON VALLEY SURGERY CENTER	LOS GATOS
564154	SIMI SURGERY CENTER, INC.	SIMI VALLEY
044162	SKYWAY SURGERY CENTER	CHICO
194960	SOLIS SURGICAL ARTS CENTER	SHERMAN OAKS
554001	SONORA EYE SURGERY CENTER	SONORA
554017	SONORA SURGERY CENTER	SONORA
434114	SOUTH BAY ENDOSCOPY CENTER, A MEDICAL CORPORATION	SAN JOSE
OSHPD ID	**Facility Name**	**City**
434175	SOUTH BAY SURGERY CENTER	MORGAN HILL
314033	SOUTH PLACER SURGERY CENTER, L.P.	GRANITE BAY
194737	SOUTHERN CALIFORNIA SURGERY CENTER	HUNTINGTON PARK
334122	SOUTHLAND ENDOSCOPY CENTER	HEMET
154075	SOUTHWEST SURGICAL CENTER	BAKERSFIELD
196176	SPALDING OUTPATIENT SURGERY CENTER	BEVERLY HILLS
564107	SPANISH HILLS SURGERY CENTER, LLC	CAMARILLO
196052	SPECIALTY SURGICAL CENTER	BEVERLY HILLS
196585	SPECIALTY SURGICAL CENTER OF ARCADIA, L.P.	ARCADIA
196524	SPECIALTY SURGICAL CENTER OF BEVERLY HILLS, L.P.	BEVERLY HILLS
196261	SPECIALTY SURGICAL CENTER OF ENCINO, L.P.	ENCINO
304333	SPECIALTY SURGICAL CENTER OF IRVINE, L.P.	IRVINE
414067	SPINAL DIAGNOSTICS AND TREATMENT CENTER, LLC	DALY CITY

424052	SPINE AND PAIN TREATMENT MEDICAL CENTER	SANTA MARIA
564136	ST. JOHN'S OUTPATIENT SURGERY CENTER	OXNARD
304190	ST. JOSEPH SURGERY AND LASER CENTER, INC.	ORANGE
196167	ST. VINCENT EYE SURGERY MEDICAL CENTER	LOS ANGELES
364061	STARPOINT HEALTH, INC.	VICTORVILLE
304056	STARPOINT SURGERY CENTER - IRVINE	IRVINE
196115	STARPOINT SURGERY CENTER, STUDIO CENTER	STUDIO CITY
334527	STERNLIEB OUTPATIENT SURGERY CENTER	RANCHO MIRAGE
394069	STOCKTON ENDOSCOPY CENTER, LLC	STOCKTON
196550	SUMMIT SURGERY CENTER	SANTA CLARITA
424049	SUMMIT SURGERY CENTER	SANTA BARBARA
105021	SUMMIT SURGICAL	FRESNO
431040	SURGECENTER OF PALO ALTO	PALO ALTO
196216	SURGERY CENTER OF LONG BEACH	LONG BEACH
454011	SURGERY CENTER OF NORTHERN CALIFORNIA	REDDING
334465	SURGERY CENTER OF RIVERSIDE, THE	RIVERSIDE
194597	SURGERY CENTER OF SANTA MONICA	SANTA MONICA
191041	SURGERY CENTER OF SOUTH BAY	TORRANCE
014022	SURGERY CTR. OF ALTA BATES SUMMIT MED. CTR, LLC, THE	OAKLAND
374162	SURGICAL EYE CARE CENTER	CARLSBAD
164016	SURGITEK OUTPATIENT CENTER, INC.	HANFORD
344066	SUTTER ALHAMBRA SURGERY CENTER, L.P.	SACRAMENTO
314010	SUTTER AUBURN SURGERY CENTER	AUBURN
484045	SUTTER FAIRFIELD SURGERY CENTER	FAIRFIELD
514021	SUTTER NORTH PROCEDURE CENTER	YUBA CITY
514032	SUTTER NORTH SURGERY CENTER	YUBA CITY
341608	SUTTER RIVER CITY SURGERY CENTER	SACRAMENTO
314035	SUTTER ROSEVILLE ENDOSCOPY CENTER	ROSEVILLE
504054	SYLVAN SURGERY CENTER, INC.	MODESTO
564022	T SURGERY CENTER	VENTURA
196175	TARZANA SURGERY CENTER, INC.	TARZANA
154104	TEHACHAPI SURGERY CENTER, INC.	TEHACHAPI
334075	TEMECULA VALLEY DAY SURGERY AND PAIN THERAPY CENTER	MURRIETA
334555	TEMECULA VALLEY ENDOSCOPY CENTER	MURRIETA
404048	TEMPLETON ENDOSCOPY CENTER	TEMPLETON
404065	TEMPLETON SURGERY CENTER LLC	TEMPLETON
OSHPD ID	**Facility Name**	**City**
196349	THE CENTER FOR AMBULATORY SURGICAL TREATMENT	WESTWOOD
334522	THE PLASTIC SURGERY INSTITUTE	RANCHO MIRAGE
196536	THIRD STREET SURGERY CENTER	LOS ANGELES
564072	THOUSAND OAKS ENDOSCOPY CENTER	THOUSAND OAKS
196262	TORRANCE SURGERY CENTER, L.P.	TORRANCE
504057	TOWER HEALTH AND WELLNESS SURGERY CENTER	TURLOCK

394066	TRACY OUTPATIENT SURGERY CENTER	TRACY
074098	TRESANTI MEDICAL CORPORATION, THE	SAN RAMON
196559	TRIANGLE SURGERY CENTER	BEVERLY HILLS
014078	TRIVALLEY OUTPATIENT SURGERY CENTER	PLEASANTON
294016	TRUCKEE SURGERY CENTER	TRUCKEE
154089	TRUXTUN SURGERY CENTER, INC.	BAKERSFIELD
584003	TWIN CITIES SURGICENTER, INC.	MARYSVILLE
196769	UNITED MEDICAL ENDOSCOPY CENTER, INC.	LANCASTER
196433	UNITED SURGERY MEDICAL CENTER	MONTEBELLO
244035	UNIVERSITY SURGERY CENTER	MERCED
364019	UPLAND OUTPATIENT SURGICAL CENTER	UPLAND
105010	UROLOGY ASSOCIATES OF CENTRAL CALIFORNIA, INC.	FRESNO
374088	UTC SURGICENTER	SAN DIEGO
194235	VALENCIA OUTPATIENT SURGICAL CENTER	SANTA CLARITA
434159	VALLEY AMBULATORY SURGERY CENTER	SAN JOSE
196504	VALLEY DIGESTIVE HEALTH CENTER, INC.	ARCADIA
134022	VALLEY ENDOSCOPY CENTER	EL CENTRO
334488	VALLEY ENDOSCOPY CENTER	HEMET
194598	VALLEY ENDOSCOPY CENTER, THE	TARZANA
104006	VALLEY MEDICAL PLAZA AMBULATORY SURGICAL CENTER	FRESNO
504046	VALLEY SURGERY CENTER, LP	MODESTO
274052	VANTAGE SURGERY CENTER	SALINAS
564133	VENTURA ENDOSCOPY CENTER, LLC	VENTURA
564048	VENTURA OUT-PATIENT SURGERY, INC.	VENTURA
564128	VENTURA SURGERY CENTER, INC.	VENTURA
544016	VISALIA CENTER FOR AMBULATORY MEDICINE AND SURGERY	VISALIA
104040	VISION CARE SURGERY CENTER	FRESNO
304135	VISTA SURGICAL CENTER, INC.	ORANGE
194268	WARDLOW SURGERY CENTER	LONG BEACH
014086	WASHINGTON OUTPATIENT SURGERY CENTER	FREMONT
434149	WAVERLEY SURGERY CENTER	PALO ALTO
014157	WEBSTER SURGERY CENTER	OAKLAND
564081	WESTLAKE EYE SURGERY CENTER	WESTLAKE VILLAGE
196803	WESTLAKE SURGICAL CENTER	WESTLAKE VILLAGE
364239	WIKA ENDOSCOPY CENTER	APPLE VALLEY
196118	WILSHIRE SURGICENTER	BEVERLY HILLS
384156	WOLFENDEN MEDICAL INSTITUTE FOR PLASTIC SURGERY	SAN FRANCISCO
104045	WOODWARD PARK SURGICENTER	FRESNO
394079	ZEITER EYE SURGICAL CENTER, INC.	STOCKTON

List of Small and Rural Hospitals
Open as of January 1, 2008
(Per Section 124840 of Health and Safety Code)

3/14/2008

Facility Name	City	County	Type of Control	GAC Beds*
Banner Lassen Medical Center	Susanville	Lassen	Non-Profit	38
Barstow Community Hospital	Barstow	San Bernardino	Investor	56
Barton Memorial Hospital	South Lake Tahoe	El Dorado	Non-Profit	73
Bear Valley Community Hospital	Big Bear Lake	San Bernardino	District	9
Biggs-Gridley Memorial Hospital	Gridley	Butte	Non-Profit	24
Catalina Island Medical Center	Avalon	Los Angeles	Non-Profit	12
Coalinga Regional Medical Center	Coalinga	Fresno	District	24
Colorado River Medical Center	Needles	San Bernardino	Investor	25
Colusa Regional Medical Center	Colusa	Colusa	Non-Profit	42
Corcoran District Hospital	Corcoran	Kings	District	32
Eastern Plumas Hospital - Loyalton Campus	Loyalton	Sierra	District	1
Eastern Plumas Hospital - Portola Campus	Portola	Plumas	District	9
Fairchild Medical Center	Yreka	Siskiyou	Non-Profit	28
Fallbrook Hospital District	Fallbrook	San Diego	District	47
Frank R Howard Memorial Hospital	Willits	Mendocino	Non-Profit	38
George L. Mee Memorial Hospital	King City	Monterey	Non-Profit	49
Glenn Medical Center	Willows	Glenn	Non-Profit	49
Hanford Community Hospital	Hanford	Kings	Non-Profit	64
Hazel Hawkins Memorial Hospital	Hollister	San Benito	District	49
Healdsburg District Hospital	Healdsburg	Sonoma	District	34
Hi-Desert Medical Center	Joshua Tree	San Bernardino	District	59
Jerold Phelps Community Hospital	Garberville	Humboldt	District	9
John C Fremont Healthcare District	Mariposa	Mariposa	District	18
Kern Valley Healthcare District	Lake Isabella	Kern	District	27

* General Acute Care beds based on 2006 Annual Utilization Reports

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Facility Name	City	County	Type of Control	GAC Beds*
Kingsburg Medical Hospital	Kingsburg	Fresno	District	15
Lompoc Healthcare District	Lompoc	Santa Barbara	District	60
Mammoth Hospital	Mammoth Lakes	Mono	District	15
Mark Twain St. Joseph'S Hospital	San Andreas	Calaveras	Non-Profit	48
Marshall Medical Center	Placerville	El Dorado	Non-Profit	91
Mayers Memorial Hospital	Fall River Mills	Shasta	District	22
Memorial Hospital Los Banos	Los Banos	Merced	Non-Profit	48
Mendocino Coast District Hospital	Fort Bragg	Mendocino	District	49
Mercy Medical Center of Mt. Shasta	Mt. Shasta	Siskiyou	Non-Profit	33
Modoc Medical Center	Alturas	Modoc	City / County	16
Mountains Community Hospital	Lake Arrowhead	San Bernardino	District	17
Northern Inyo Hospital	Bishop	Inyo	District	25
Oak Valley District Hospital	Oakdale	Stanislaus	District	35
Ojai Valley Community Hospital	Ojai	Ventura	Non-Profit	37
Palm Drive Hospital	Sebastopol	Sonoma	District	37
Palo Verde Hospital	Blythe	Riverside	Investor	51
Pioneers Memorial Hospital	Brawley	Imperial	District	107
Plumas District Hospital	Quincy	Plumas	District	26
Redbud Community Hospital	Clearlake	Lake	Non-Profit	32
Redwood Memorial Hospital	Fortuna	Humboldt	Non-Profit	35
Ridgecrest Regional Hospital	Ridgecrest	Kern	Non-Profit	80
San Gorgonio Memorial Hospital	Banning	Riverside	District	61
Santa Ynez Valley Cottage Hospital	Solvang	Santa Barbara	Non-Profit	20
Selma Community Hospital	Selma	Fresno	Non-Profit	57

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Facility Name	City	County	Type of Control	GAC Beds*
Seneca Healthcare District	Chester	Plumas	District	10
Seton Medical Center - Coastside	Moss Beach	San Mateo	Non-Profit	5
Sierra Kings District Hospital	Reedley	Fresno	District	44
Sierra Nevada Memorial Hospital	Grass Valley	Nevada	Non-Profit	104
Southern Inyo Hospital	Lone Pine	Inyo	District	4
St. Elizabeth Community Hospital	Red Bluff	Tehama	Non-Profit	76
St. Mary Regional Medical Center	Apple Valley	San Bernardino	Non-Profit	166
Surprise Valley Community Hospital	Cedarville	Modoc	District	4
Sutter Amador Hospital	Jackson	Amador	Non-Profit	42
Sutter Coast Hospital	Crescent City	Del Norte	Non-Profit	59
Sutter Lakeside Hospital	Lakeport	Lake	Non-Profit	69
Tahoe Forest Hospital	Truckee	Nevada	District	35
Tehachapi Hospital	Tehachapi	Kern	District	28
Trinity Hospital	Weaverville	Trinity	City / County	25
Tuolumne General Hospital	Tuolumne	Sonora	City / County	21
Twin Cities Community Hospital	Templeton	San Luis Obispo	Investor	84
Ukiah Valley Medical Center-Hospital Dr	Ukiah	Mendocino	Non-Profit	78
Victor Valley Community Hospital	Victorville	San Bernardino	Non-Profit	99

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106010735	ALAMEDA HOSPITAL	2070 CLINTON	ALAMEDA	94501	1	Alameda	GAC	135	Basic
106010739	ALTA BATES SUMMIT MED CTR-ALTA BATES CAMPUS	2450 ASHBY STREET	BERKELEY	94705	1	Alameda	GAC	347	Basic
106010776	CHILDRENS HOSPITAL AND RESEARCH CTR AT OAKLAND	747 52ND STREET	OAKLAND	94609	1	Alameda	GAC	190	Basic
106010782	THUNDER ROAD CHEMICAL DEPENDENCY RECOVERY HOSPITAL	390 FORTIETH STREET	OAKLAND	94609	1	Alameda	CDRH	50	
106010805	EDEN MEDICAL CENTER	20103 LAKE CHABOT ROAD	CASTRO VALLEY	94546	1	Alameda	GAC	234	Basic
106010811	ALAMEDA CO MED CTR - FAIRMONT CAMPUS	15400 FOOTHILL BOULEVARD	SAN LEANDRO	94578	1	Alameda	GAC	159	
106010844	ALTA BATES SUMMIT MED CTR-HERRICK CAMPUS	2001 DWIGHT WAY	BERKELEY	94704	1	Alameda	GAC	180	
106010846	ALAMEDA CO MED CTR - HIGHLAND CAMPUS	1411 EAST 31ST STREET	OAKLAND	94602	1	Alameda	GAC	316	Basic
106010856	KAISER FND HOSP - OAKLAND CAMPUS	280 W. MACARTHUR BOULEVARD	OAKLAND	94611-	1	Alameda	GAC	345	Basic
106010858	KAISER FND HOSP - HAYWARD	27400 HESPERIAN BOULEVARD	HAYWARD	94545	1	Alameda	GAC	210	Basic
106010869	LAUREL GROVE HOSPITAL	19933 LAKE CHABOT ROAD	CASTRO VALLEY	94546	1	Alameda	GAC	31	
106010887	KINDRED HOSPITAL - SAN FRANCISCO BAY AREA	2800 BENEDICT DRIVE	SAN LEANDRO	94577	1	Alameda	GAC	99	
106010937	ALTA BATES SUMMIT MED CTR-SUMMIT CAMPUS-HAWTHORNE	350 HAWTHORNE AVENUE	OAKLAND	94609	1	Alameda	GAC	337	Basic
106010967	ST. ROSE HOSPITAL	27200 CALAROGA AVENUE	HAYWARD	94545	1	Alameda	GAC	163	Basic
106010983	VALLEY MEMORIAL HOSPITAL - LIVERMORE	1111 E. STANLEY BOULEVARD	LIVERMORE	94550	1	Alameda	GAC	75	
106010987	WASHINGTON HOSPITAL - FREMONT	2000 MOWRY AVENUE	FREMONT	94538	1	Alameda	GAC	337	Basic
106013619	SAN LEANDRO HOSPITAL	13855 EAST 14TH STREET	SAN LEANDRO	94578	1	Alameda	GAC	122	Basic
106013626	ALTA BATES SUMMIT MED CTR-SUMMIT CAMPUS-SUMMIT	3100 SUMMIT STREET	OAKLAND	94609	1	Alameda	GAC	172	
106013687	MPI CHEMICAL DEPENDENCY RECOVERY HOSPITAL	3012 SUMMIT STREET, 5TH FLOOR	OAKLAND	94609	1	Alameda	CDRH	24	
106014034	FREMONT HOSPITAL	39001 SUNDALE DRIVE	FREMONT	94538	1	Alameda	PSYCH	96	
106014050	VALLEYCARE MEDICAL CENTER	5555 WEST LAS POSITAS BLVD.	PLEASANTON	94588	1	Alameda	GAC	137	Basic
106014132	KAISER FND HOSP - FREMONT	39400 PASEO PADRE PARKWAY	FREMONT	94538	1	Alameda	GAC	106	Basic
106014207	TELECARE HERITAGE PSYCHIATRIC HEALTH FACILITY	2633 East 27th Street	Oakland	94601	1	Alameda	PHF	26	
106014226	Telecare Willow Rock Center	2050 Fairmont Drive	Alameda	94578	1	Alameda	PHF	16	
106034002	SUTTER AMADOR HOSPITAL	200 MISSION BLVD	JACKSON	95642	3	Amador	GAC	66	Basic
106040802	BIGGS GRIDLEY MEMORIAL HOSPITAL	240 SPRUCE STREET	GRIDLEY	95948	4	Butte	GAC	45	Standby
106040828	ENLOE MEDICAL CENTER - COHASSET CAMPUS	560 COHASSET ROAD	CHICO	95926	4	Butte	GAC	123	
106040875	FEATHER RIVER HOSPITAL	5974 PENTZ ROAD	PARADISE	95969	4	Butte	GAC	101	Basic
106040937	OROVILLE HOSPITAL	2767 OLIVE HIGHWAY	OROVILLE	95966	4	Butte	GAC	153	Basic
106040962	ENLOE MEDICAL CENTER- ESPLANADE CAMPUS	1531 ESPLANADE	CHICO	95926	4	Butte	GAC	208	Basic
106044006	BUTTE COUNTY PHF	592 RIO LINDO AVENUE	CHICO	95926	4	Butte	PHF	16	
106044011	ENLOE REHABILITATION CENTER	340 WEST EAST AVENUE	CHICO	95926	4	Butte	GAC	60	
106050932	MARK TWAIN ST. JOSEPH'S HOSPITAL	768 MOUNTAIN RANCH ROAD	SAN ANDREAS	95249	5	Calaveras	GAC	48	Basic
106060870	COLUSA REGIONAL MEDICAL CENTER	199 EAST WEBSTER STREET	COLUSA	95932	6	Colusa	GAC	48	Standby
106070904	DOCTORS MEDICAL CENTER - SAN PABLO/PINOLE	2000 VALE ROAD	SAN PABLO	94806	7	Contra Costa	GAC	247	Basic
106070924	CONTRA COSTA REGIONAL MEDICAL CENTER	2500 ALHAMBRA AVENUE	MARTINEZ	94553	7	Contra Costa	GAC	166	Basic
106070934	SUTTER DELTA MEDICAL CENTER	3901 LONE TREE WAY	ANTIOCH	94509	7	Contra Costa	GAC	145	Basic
106070988	JOHN MUIR MEDICAL CENTER-WALNUT CREEK CAMPUS	1601 YGNACIO VALLEY ROAD	WALNUT CREEK	94598	7	Contra Costa	GAC	327	Basic
106070990	KAISER FND HOSP - WALNUT CREEK	1425 SOUTH MAIN STREET	WALNUT CREEK	94596-	7	Contra Costa	GAC	233	Basic
106071018	JOHN MUIR MEDICAL CENTER-CONCORD CAMPUS	2540 EAST STREET	CONCORD	94520	7	Contra Costa	GAC	254	Basic
106074011	SAN RAMON REGIONAL MEDICAL CENTER SOUTH BUILDING	7777 NORRIS CANYON ROAD	SAN RAMON	94583	7	Contra Costa	GAC	64	
106074017	SAN RAMON REGIONAL MEDICAL CENTER	6001 NORRIS CANYON ROAD	SAN RAMON	94583	7	Contra Costa	GAC	123	Basic
106074039	JOHN MUIR BEHAVIORAL HEALTH CENTER	2740 GRANT STREET	CONCORD	94520	7	Contra Costa	PSYCH	73	
106074093	KAISER FND HOSP - RICHMOND CAMPUS	901 NEVIN	RICHMOND	94804	7	Contra Costa	GAC	50	Basic
106074097	KAISER FOUND HSP-ANTIOCH	4501 SAND CREEK ROAD	ANTIOCH	94531	7	Contra Costa	GAC	130	Basic
106084001	SUTTER COAST HOSPITAL	800 EAST WASHINGTON BOULEVARD	CRESCENT CITY	95531	8	Del Norte	GAC	59	Basic
106090793	BARTON MEMORIAL HOSPITAL	2170 SOUTH AVENUE	SOUTH LAKE TAHOE	96150	9	El Dorado	GAC	121	Basic
106090933	MARSHALL MEDICAL CENTER (1-RH)	1100 MARSHALL WAY	PLACERVILLE	95667	9	El Dorado	GAC	105	Basic
106094002	EL DORADO COUNTY P H F	935-B SPRING STREET	PLACERVILLE	95667	9	El Dorado	PHF	15	

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106100005	COMMUNITY MEDICAL CENTER - CLOVIS	2755 HERNDON AVENUE	CLOVIS	93612	10	Fresno	GAC	109	Basic
106100697	COALINGA REGIONAL MEDICAL CENTER	1191 PHELPS AVENUE	COALINGA	93210	10	Fresno	GAC	138	Standby
106100717	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	2823 FRESNO AND R STREETS	FRESNO	93721	10	Fresno	GAC	459	Basic
106100745	KINGSBURG MEDICAL CENTER	1200 SMITH STREET	KINGSBURG	93631	10	Fresno	GAC	35	Standby
106100791	CENTRAL VALLEY ORTHOPEDIC AND SPINE INSTITUTE	2558 JENSEN AVENUE	SANGER	93657	10	Fresno	GAC	31	
106100793	SELMA COMMUNITY HOSPITAL	1141 ROSE AVENUE	SELMA	93662	10	Fresno	GAC	57	Standby
106100797	SIERRA KINGS DISTRICT HOSPITAL	372 WEST CYPRESS AVENUE	REEDLEY	93654	10	Fresno	GAC	44	Standby
106100822	UNIVERSITY MEDICAL CENTER	445 SOUTH CEDAR AVENUE	FRESNO	93702	10	Fresno	GAC	270	Comprehensive
106100899	ST. AGNES MEDICAL CENTER	1303 EAST HERNDON AVENUE	FRESNO	93710	10	Fresno	GAC	436	Basic
106104008	COMMUNITY BEHAVIORAL HEALTH CENTER	7171 NORTH CEDAR AVENUE	FRESNO	93720	10	Fresno	GAC	61	
106104023	SAN JOAQUIN VALLEY REHABILITATION HOSPITAL	7173 NO. SHARON AVENUE	FRESNO	93720	10	Fresno	GAC	62	
106104047	FRESNO SURGICAL HOSPITAL	6125 NORTH FRESNO STREET	FRESNO	93710	10	Fresno	GAC	20	
106104062	KAISER FND HOSP - FRESNO	7300 NORTH FRESNO STREET	FRESNO	93720	10	Fresno	GAC	169	Basic
106104089	FRESNO COUNTY PSYCHIATRIC HEALTH FACILITY	4411 E. KINGS CANYON ROAD	FRESNO	93702	10	Fresno	PHF	16	
106105029	FRESNO HEART AND SURGICAL HOSPITAL	15 E. Audubon Drive	FRESNO	93720	10	Fresno	GAC	57	
106105051	COALINGA STATE HOSPITAL	24511 WEST JAYNE AVENUE	COALINGA	93210	10	Fresno	PSYCH	1500	
106110889	GLENN MEDICAL CENTER	1133 WEST SYCAMORE STREET	WILLOWS	95988	11	Glenn	GAC	47	Standby
106120981	GENERAL HOSPITAL, THE	2200 HARRISON AVENUE	EUREKA	95501	12	Humboldt	GAC	43	
106121002	MAD RIVER COMMUNITY HOSPITAL	3800 JANES ROAD	ARCATA	95521	12	Humboldt	GAC	78	Basic
106121031	JEROLD PHELPS COMMUNITY HOSPITAL	733 CEDAR STREET	GARBERVILLE	95542	12	Humboldt	GAC	17	Standby
106121051	REDWOOD MEMORIAL HOSPITAL	3300 RENNER DRIVE	FORTUNA	95540	12	Humboldt	GAC	35	Basic
106121080	ST. JOSEPH HOSPITAL - EUREKA	2700 DOLBEER STREET	EUREKA	95501	12	Humboldt	GAC	146	Basic
106124004	SEMPERVIRENS P.H.F.	720 WOOD STREET	EUREKA	95501	12	Humboldt	PHF	16	
106130699	EL CENTRO REGIONAL MEDICAL CENTER	1415 ROSS AVENUE	EL CENTRO	92243	13	Imperial	GAC	165	Basic
106130760	PIONEERS MEMORIAL HOSPITAL	207 WEST LEGION ROAD	BRAWLEY	92227	13	Imperial	GAC	107	Basic
106141273	NORTHERN INYO HOSPITAL	150 PIONEER LANE	BISHOP	93514	14	Inyo	GAC	25	Basic
106141338	SOUTHERN INYO HOSPITAL	501 EAST LOCUST STREET	LONE PINE	93545	14	Inyo	GAC	37	Standby
106150706	DELANO REGIONAL MEDICAL CENTER	1401 GARCES HIGHWAY	DELANO	93215	15	Kern	GAC	156	Basic
106150722	BAKERSFIELD MEMORIAL HOSPITAL- 34TH STREET	420 - 34TH STREET	BAKERSFIELD	93301	15	Kern	GAC	307	Basic
106150736	KERN MEDICAL CENTER	1830 FLOWER STREET	BAKERSFIELD	93305-	15	Kern	GAC	222	Basic
106150737	KERN VALLEY HEALTHCARE DISTRICT	6412 LAUREL AVENUE	LAKE ISABELLA	93240	15	Kern	GAC	101	Standby
106150761	MERCY HOSPITAL - BAKERSFIELD	2215 TRUXTUN AVENUE	BAKERSFIELD	93301	15	Kern	GAC	194	Basic
106150775	GOOD SAMARITAN HOSPITAL-BAKERSFIELD	901 OLIVE DRIVE	BAKERSFIELD	93308	15	Kern	GAC	124	
106150782	RIDGECREST REGIONAL HOSPITAL	1081 NORTH CHINA LAKE BLVD.	RIDGECREST	93555	15	Kern	GAC	80	Basic
106150788	SAN JOAQUIN COMMUNITY HOSPITAL	2615 CHESTER AVENUE	BAKERSFIELD	93301	15	Kern	GAC	299	Basic
106150808	TEHACHAPI HOSPITAL	115 WEST E STREET	TEHACHAPI	93561	15	Kern	GAC	28	Standby
106150830	MERCY WESTSIDE HOSPITAL	110 EAST NORTH STREET	TAFT	93268	15	Kern	GAC	84	
106154022	HEALTHSOUTH BAKERSFIELD REHABILITATION HOSPITAL	5001 COMMERCE DRIVE	BAKERSFIELD	93309	15	Kern	GAC	60	
106154101	BAKERSFIELD HEART HOSPITAL	3001 SILLECT AVENUE	BAKERSFIELD	93308	15	Kern	GAC	47	Basic
106154108	MERCY SOUTHWEST HOSPITAL	400 OLD RIVER RD	BAKERSFIELD	93311	15	Kern	GAC	75	Basic
106160702	CORCORAN DISTRICT HOSPITAL	1310 HANNA AVENUE	CORCORAN	93212	16	Kings	GAC	32	Standby
106160725	HANFORD COMMUNITY MEDICAL CENTER	450 GREENFIELD AVENUE	HANFORD	93230	16	Kings	GAC	64	Basic
106160787	CENTRAL VALLEY GENERAL HOSPITAL	1025 NORTH DOUTY STREET	HANFORD	93230	16	Kings	GAC	49	Standby
106171049	REDBUD COMMUNITY HOSPITAL	15630 18TH AVE - HWY 53	CLEARLAKE	95422	17	Lake	GAC	32	Standby
106171395	SUTTER LAKESIDE HOSPITAL	5176 HILL ROAD EAST	LAKEPORT	95453	17	Lake	GAC	69	Basic
106184008	BANNER LASSEN MEDICAL CENTER	1800 SPRING RIDGE DRIVE	SUSANVILLE	96130	18	Lassen	GAC	38	Basic
106190017	ALHAMBRA HOSPITAL	100 SOUTH RAYMOND AVENUE	ALHAMBRA	91801	19	Los Angeles	GAC	144	Basic
106190020	BHC ALHAMBRA HOSPITAL	4619 ROSEMEAD BOULEVARD	ROSEMEAD	91770	19	Los Angeles	PSYCH	85	
106190034	ANTELOPE VALLEY HOSPITAL MEDICAL CENTER	1600 WEST AVENUE J	LANCASTER	93534	19	Los Angeles	GAC	420	Basic

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106190045	CATALINA ISLAND MEDICAL CENTER	100 FALLS CANYON ROAD	AVALON	90704	19	Los Angeles	GAC	12	Standby
106190049	VISTA HOSPITAL OF SAN GABRIEL VALLEY	14148 FRANCISQUITO AVENUE	BALDWIN PARK	91706	19	Los Angeles	GAC	95	
106190052	BARLOW RESPIRATORY HOSPITAL	2000 STADIUM WAY	LOS ANGELES	90026	19	Los Angeles	GAC	105	
106190053	ST. MARY MEDICAL CENTER	1050 LINDEN AVENUE, BOX 887	LONG BEACH	90801	19	Los Angeles	GAC	389	Basic
106190066	BELLFLOWER MEDICAL CENTER	9542 EAST ARTESIA BOULEVARD	BELLFLOWER	90706	19	Los Angeles	GAC	144	Basic
106190081	BEVERLY HOSPITAL	309 WEST BEVERLY BOULEVARD	MONTEBELLO	90640	19	Los Angeles	GAC	223	Basic
106190110	BROTMAN MEDICAL CENTER	3828 DELMAS TERRACE	CULVER CITY	90231	19	Los Angeles	GAC	420	Basic
106190125	CALIFORNIA HOSPITAL MEDICAL CENTER - LOS ANGELES	1401 SOUTH GRAND AVENUE	LOS ANGELES	90015	19	Los Angeles	GAC	316	Basic
106190135	KAISER FND HOSP - CARSON	23621 SOUTH MAIN STREET	CARSON	90745	19	Los Angeles	GAC	20	
106190137	CASA COLINA HOSPITAL FOR REHAB MEDICINE	255 EAST BONITA AVENUE	POMONA	91767	19	Los Angeles	GAC	68	
106190148	CENTINELA FREEMAN REG MED CTR-CENTINELA CAMPUS	555 EAST HARDY STREET	INGLEWOOD	90301	19	Los Angeles	GAC	369	Basic
106190150	KEDREN COMMUNITY MENTAL HEALTH CENTER	4211 SOUTH AVALON BOULEVARD	LOS ANGELES	90011	19	Los Angeles	PSYCH	66	
106190155	CENTURY CITY DOCTORS HOSPITAL	2070 CENTURY PARK EAST	LOS ANGELES	90067	19	Los Angeles	GAC	176	Basic
106190159	TRI-CITY REGIONAL MEDICAL CENTER	21530 SOUTH PIONEER BOULEVARD	HAWAIIAN GARDENS	90716	19	Los Angeles	GAC	137	Basic
106190163	AURORA CHARTER OAK	1161 EAST COVINA BOULEVARD	COVINA	91724	19	Los Angeles	PSYCH	95	
106190170	CHILDREN'S HOSPITAL OF LOS ANGELES	4650 SUNSET BOULEVARD	LOS ANGELES	90027	19	Los Angeles	GAC	286	Basic
106190176	CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	1500 EAST DUARTE ROAD	DUARTE	91010	19	Los Angeles	GAC	217	
106190184	COLLEGE HOSPITAL	10802 COLLEGE PLACE	CERRITOS	90701	19	Los Angeles	PSYCH	157	
106190196	VISTA HOSPITAL OF SOUTH BAY	1246 WEST 155TH STREET	GARDENA	90247	19	Los Angeles	GAC	58	
106190197	COMMUNITY AND MISSION HSP OF HNTG PK - SLAUSON	2623 EAST SLAUSON AVENUE	HUNTINGTON PARK	90255	19	Los Angeles	GAC	81	Standby
106190198	LOS ANGELES COMMUNITY HOSPITAL	4081 EAST OLYMPIC BOULEVARD	LOS ANGELES	90023	19	Los Angeles	GAC	130	Standby
106190200	SAN GABRIEL VALLEY MEDICAL CENTER	438 W. LAS TUNAS DRIVE	SAN GABRIEL	91776	19	Los Angeles	GAC	273	Basic
106190230	CENTINELA FREEMAN REG MED CTR-MEMORIAL CAMPUS	333 NORTH PRAIRIE AVENUE	INGLEWOOD	90301	19	Los Angeles	GAC	53	
106190232	DEL AMO HOSPITAL	23700 CAMINO DEL SOL	TORRANCE	90505	19	Los Angeles	PSYCH	166	
106190240	LAKEWOOD REGIONAL MEDICAL CENTER	3700 EAST SOUTH STREET	LAKEWOOD	90712	19	Los Angeles	GAC	172	Basic
106190243	DOWNEY REGIONAL MEDICAL CENTER	11500 BROOKSHIRE AVENUE	DOWNEY	90241	19	Los Angeles	GAC	199	Basic
106190256	EAST LOS ANGELES DOCTORS HOSPITAL	4060 WHITTIER BOULEVARD	LOS ANGELES	90023	19	Los Angeles	GAC	127	Basic
106190280	ENCINO-TARZANA REGIONAL MED CTR-ENCINO	16237 VENTURA BOULEVARD	ENCINO	91436	19	Los Angeles	GAC	151	Basic
106190298	FOOTHILL PRESBYTERIAN HOSPITAL-JOHNSTON MEMORIAL	250 SOUTH GRAND AVENUE	GLENDORA	91741	19	Los Angeles	GAC	105	Basic
106190305	KINDRED HOSPITAL - LOS ANGELES	5525 WEST SLAUSON AVENUE	LOS ANGELES	90056	19	Los Angeles	GAC	81	
106190307	PACIFIC ALLIANCE MEDICAL CENTER, INC.	531 WEST COLLEGE STREET	LOS ANGELES	90012	19	Los Angeles	GAC	142	
106190315	GARFIELD MEDICAL CENTER	525 NORTH GARFIELD AVENUE	MONTEREY PARK	91754	19	Los Angeles	GAC	210	Basic
106190317	GATEWAYS HOSPITAL AND MENTAL HEALTH CENTER	1891 EFFIE STREET	LOS ANGELES	90026	19	Los Angeles	PSYCH	55	
106190323	GLENDALE ADVENTIST MEDICAL CENTER - WILSON TERRACE	1509 EAST WILSON TERRACE	GLENDALE	91206	19	Los Angeles	GAC	508	Basic
106190328	EAST VALLEY HOSPITAL MEDICAL CENTER	150 WEST ROUTE 66	GLENDORA	91740	19	Los Angeles	GAC	128	Basic
106190352	GREATER EL MONTE COMMUNITY HOSPITAL	1701 SANTA ANITA AVENUE	SOUTH EL MONTE	91733	19	Los Angeles	GAC	117	Basic
106190380	HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD	6245 DE LONGPRE AVENUE	HOLLYWOOD	90028	19	Los Angeles	GAC	100	
106190382	HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	1300 NORTH VERMONT AVENUE	LOS ANGELES	90027	19	Los Angeles	GAC	434	Basic
106190385	PROVIDENCE HOLY CROSS MEDICAL CENTER	15031 RINALDI STREET	MISSION HILLS	91345	19	Los Angeles	GAC	254	Basic
106190392	GOOD SAMARITAN HOSPITAL-LOS ANGELES	1225 WILSHIRE BOULEVARD	LOS ANGELES	90017	19	Los Angeles	GAC	408	Basic
106190400	HUNTINGTON MEMORIAL HOSPITAL	100 W. CALIFORNIA BOULEVARD	PASADENA	91105	19	Los Angeles	GAC	522	Basic
106190410	CITY OF ANGELS MEDICAL CENTER-INGLESIDE CAMPUS	7500 EAST HELLMAN AVENUE	ROSEMEAD	91770	19	Los Angeles	GAC	70	
106190413	CITRUS VALLEY MEDICAL CENTER - IC CAMPUS	210 W. SAN BERNARDINO ROAD	COVINA	91723	19	Los Angeles	GAC	222	Basic
106190422	TORRANCE MEMORIAL MEDICAL CENTER	3330 WEST LOMITA BOULEVARD	TORRANCE	90505-	19	Los Angeles	GAC	376	Basic
106190429	KAISER FND HOSP - SUNSET	4867 SUNSET BOULEVARD	LOS ANGELES	90027	19	Los Angeles	GAC	439	Basic
106190430	KAISER FND HOSP - BELLFLOWER	9400 EAST ROSECRANS AVENUE	BELLFLOWER	90706	19	Los Angeles	GAC	352	Basic
106190431	KAISER FND HOSP - HARBOR CITY	25825 SOUTH VERMONT AVENUE	HARBOR CITY	90710	19	Los Angeles	GAC	235	Basic
106190432	KAISER FND HOSP - PANORAMA CITY	13652 CANTARA STREET	PANORAMA CITY	91402	19	Los Angeles	GAC	262	Basic
106190434	KAISER FND HOSP - WEST LA	6041 CADILLAC AVENUE	LOS ANGELES	90034	19	Los Angeles	GAC	305	Basic

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106190449	KINDRED HOSPITAL - LA MIRADA	14900 EAST IMPERIAL HIGHWAY	LA MIRADA	90637-	19	Los Angeles	GAC	118	
106190455	LANCASTER COMMUNITY HOSPITAL	43830 NORTH 10TH STREET WEST	LANCASTER	93534	19	Los Angeles	GAC	117	Basic
106190458	KINDRED HOSPITAL - SAN GABRIEL VALLEY	845 NORTH LARK ELLEN AVENUE	WEST COVINA	91791	19	Los Angeles	GAC	76	
106190462	AURORA LAS ENCINAS HOSPITAL, LLC	2900 EAST DEL MAR BOULEVARD	PASADENA	91107	19	Los Angeles	PSYCH	118	
106190468	PROMISE HOSPITAL OF EAST LOS ANGELES-EAST L.A. CAMPUS	443 SOUTH SOTO STREET	LOS ANGELES	90033	19	Los Angeles	GAC	36	
106190470	LITTLE COMPANY OF MARY HOSPITAL	4101 TORRANCE BOULEVARD	TORRANCE	90503	19	Los Angeles	GAC	434	Basic
106190475	COMMUNITY HOSPITAL OF LONG BEACH	1720 TERMINO AVENUE	LONG BEACH	90804	19	Los Angeles	GAC	256	Basic
106190477	PACIFIC HOSPITAL-SOUTH CAMPUS D/P APH	1725 PACIFIC AVENUE	LONG BEACH	90813	19	Los Angeles	GAC	36	
106190500	CENTINELA FREEMAN REG MED CTR-MARINA CAMPUS	4650 LINCOLN BOULEVARD	MARINA DEL REY	90291	19	Los Angeles	GAC	145	Basic
106190517	ENCINO-TARZANA REGIONAL MED CTR-TARZANA	18321 CLARK STREET	TARZANA	91356	19	Los Angeles	GAC	245	Basic
106190521	MEMORIAL HOSPITAL OF GARDENA	1145 W. REDONDO BEACH BLVD.	GARDENA	90247	19	Los Angeles	GAC	172	Basic
106190522	GLENDALE MEMORIAL HOSPITAL AND HEALTH CENTER	1420 SOUTH CENTRAL AVENUE	GLENDALE	91204	19	Los Angeles	GAC	334	Basic
106190524	MISSION COMMUNITY HOSPITAL - PANORAMA CAMPUS	14850 ROSCOE BOULEVARD	PANORAMA CITY	91402	19	Los Angeles	GAC	145	Basic
106190525	LONG BEACH MEMORIAL MEDICAL CENTER	2801 ATLANTIC AVENUE	LONG BEACH	90806	19	Los Angeles	GAC	462	Basic
106190529	METHODIST HOSPITAL OF SOUTHERN CALIFORNIA	300 WEST HUNTINGTON DRIVE	ARCADIA	91007	19	Los Angeles	GAC	460	Basic
106190534	OLYMPIA MEDICAL CENTER	5925 SAN VICENTE BOULEVARD	LOS ANGELES	90019	19	Los Angeles	GAC	204	Basic
106190538	COMMUNITY AND MISSION HSP OF HNTG PARK-FLORENCE	3111 EAST FLORENCE AVENUE	HUNTINGTON PARK	90255	19	Los Angeles	GAC	109	
106190541	MONROVIA COMMUNITY HOSPITAL	323 SOUTH HELIOTROPE AVENUE	MONROVIA	91016	19	Los Angeles	GAC	49	
106190547	MONTEREY PARK HOSPITAL	900 SOUTH ATLANTIC BOULEVARD	MONTEREY PARK	91754-	19	Los Angeles	GAC	101	Basic
106190552	MOTION PICTURE AND TELEVISION HOSPITAL	23388 MULHOLLAND DRIVE	WOODLAND HILLS	91364	19	Los Angeles	GAC	250	
106190555	CEDARS SINAI MEDICAL CENTER	8700 BEVERLY BOULEVARD	LOS ANGELES	90048	19	Los Angeles	GAC	952	Basic
106190568	NORTHRIDGE HOSPITAL MEDICAL CENTER	18300 ROSCOE BOULEVARD	NORTHRIDGE	91328	19	Los Angeles	GAC	411	Basic
106190570	NORWALK COMMUNITY HOSPITAL	13222 BLOOMFIELD AVENUE	NORWALK	90650	19	Los Angeles	GAC	50	Basic
106190587	PACIFIC HOSPITAL OF LONG BEACH	2776 PACIFIC AVENUE	LONG BEACH	90806	19	Los Angeles	GAC	148	Basic
106190599	PROMISE HOSPITAL OF EAST LOS ANGELES-SUBURBAN CAMPUS	16453 SOUTH COLORADO AVENUE	PARAMOUNT	90723	19	Los Angeles	GAC	177	
106190630	POMONA VALLEY HOSPITAL MEDICAL CENTER	1798 NORTH GAREY AVENUE	POMONA	91767	19	Los Angeles	GAC	453	Basic
106190631	PRESBYTERIAN INTERCOMMUNITY HOSPITAL	12401 EAST WASHINGTON BLVD.	WHITTIER	90602	19	Los Angeles	GAC	444	Basic
106190636	CITRUS VALLEY MEDICAL CENTER - QV CAMPUS	1115 SOUTH SUNSET AVENUE	WEST COVINA	91790	19	Los Angeles	GAC	325	Basic
106190646	KAISER FND HOSP - MENTAL HEALTH CENTER	765 COLLEGE STREET	LOS ANGELES	90012	19	Los Angeles	GAC	68	
106190661	CITY OF ANGELS MEDICAL CENTER-DOWNTOWN CAMPUS	1711 WEST TEMPLE STREET	LOS ANGELES	90026	19	Los Angeles	GAC	145	
106190673	SAN DIMAS COMMUNITY HOSPITAL	1350 WEST COVINA BOULEVARD	SAN DIMAS	91773	19	Los Angeles	GAC	64	Basic
106190680	LITTLE COMPANY OF MARY - SAN PEDRO HOSPITAL	1300 WEST SEVENTH STREET	SAN PEDRO	90732	19	Los Angeles	GAC	356	Basic
106190681	MIRACLE MILE MEDICAL CENTER	6000 SAN VICENTE BOULEVARD	LOS ANGELES	90036	19	Los Angeles	GAC	17	
106190687	SANTA MONICA - UCLA MEDICAL CENTER	1250 16TH STREET	SANTA MONICA	90404	19	Los Angeles	GAC	279	Basic
106190696	PACIFICA HOSPITAL OF THE VALLEY	9449 SAN FERNANDO ROAD	SUN VALLEY	91352	19	Los Angeles	GAC	231	Basic
106190708	SHERMAN OAKS HOSPITAL	4929 VAN NUYS BOULEVARD	SHERMAN OAKS	91403	19	Los Angeles	GAC	153	Basic
106190712	SHRINERS HOSPITAL FOR CHILDREN - L.A.	3160 GENEVA STREET	LOS ANGELES	90020-	19	Los Angeles	GAC	60	
106190754	ST. FRANCIS MEDICAL CENTER	3630 IMPERIAL HIGHWAY	LYNWOOD	90262	19	Los Angeles	GAC	384	Basic
106190756	ST. JOHN'S HEALTH CENTER	1328 - 22ND STREET	SANTA MONICA	90404	19	Los Angeles	GAC	340	Basic
106190758	PROVIDENCE SAINT JOSEPH MEDICAL CENTER	501 SO. BUENA VISTA	BURBANK	91505-	19	Los Angeles	GAC	448	Basic
106190762	ST. VINCENT MEDICAL CENTER	2131 WEST 3RD STREET	LOS ANGELES	90057	19	Los Angeles	GAC	347	Standby
106190766	COAST PLAZA DOCTORS HOSPITAL	13100 SOUTH STUDEBAKER ROAD	NORWALK	90650	19	Los Angeles	GAC	123	Basic
106190782	TARZANA TREATMENT CENTER	18646 OXNARD STREET	TARZANA	91356	19	Los Angeles	PSYCH	60	
106190784	TEMPLE COMMUNITY HOSPITAL	235 NORTH HOOVER STREET	LOS ANGELES	90004	19	Los Angeles	GAC	170	
106190796	UCLA MEDICAL CENTER	10833 LECONTE AVENUE	LOS ANGELES	90095	19	Los Angeles	GAC	669	Comprehensive
106190812	VALLEY PRESBYTERIAN HOSPITAL	15107 VAN OWEN STREET	VAN NUYS	91405	19	Los Angeles	GAC	350	Basic
106190814	HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS	14433 EMELITA STREET	VAN NUYS	91401	19	Los Angeles	GAC	59	
106190818	VERDUGO HILLS HOSPITAL	1812 VERDUGO BOULEVARD	GLENDALE	91208	19	Los Angeles	GAC	158	Basic
106190854	LOS ANGELES METROPOLITAN MEDICAL CENTER	2231 SOUTH WESTERN AVENUE	LOS ANGELES	90018	19	Los Angeles	GAC	213	Basic

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106190857	DOCTORS HOSPITAL OF WEST COVINA, INC	725 SOUTH ORANGE AVENUE	WEST COVINA	91790	19	Los Angeles	GAC	51	
106190859	WEST HILLS HOSPITAL AND MEDICAL CENTER	7300 MEDICAL CENTER DRIVE	CANOGA PARK	91307	19	Los Angeles	GAC	236	Basic
106190878	WHITE MEMORIAL MEDICAL CENTER	1720 CESAR E. CHAVEZ AVENUE	LOS ANGELES	90033	19	Los Angeles	GAC	430	Basic
106190883	WHITTIER HOSPITAL MEDICAL CENTER	9080 COLIMA ROAD	WHITTIER	90605	19	Los Angeles	GAC	178	Basic
106190930	RESNICK NEUROPSYCHIATRIC HOSPITAL AT UCLA	760 WESTWOOD PLAZA	LOS ANGELES	90024-	19	Los Angeles	PSYCH	136	
106190949	HENRY MAYO NEWHALL MEMORIAL HOSPITAL	23845 WEST MCBEAN PARKWAY	VALENCIA	91355	19	Los Angeles	GAC	217	Basic
106190958	METROPOLITAN STATE HOSPITAL	11400 SOUTH NORWALK BOULEVARD	NORWALK	90650	19	Los Angeles	PSYCH	1254	
106191014	LANTERMAN DEVELOPMENTAL CENTER	3530 POMONA BOULEVARD	POMONA	91768	19	Los Angeles	GAC	1258	
106191216	USC KENNETH NORRIS, JR. CANCER HOSPITAL	1441 EASTLAKE AVENUE	LOS ANGELES	90033	19	Los Angeles	GAC	60	
106191225	TOM REDGATE MEMORIAL RECOVERY CENTER	1775 CHESTNUT STREET	LONG BEACH	90813	19	Los Angeles	CDRH	63	
106191227	LOS ANGELES CO HARBOR-UCLA MEDICAL CENTER	1000 WEST CARSON STREET	TORRANCE	90502	19	Los Angeles	GAC	570	Basic
106191228	LOS ANGELES CO USC MEDICAL CENTER	1200 NORTH STATE STREET	LOS ANGELES	90033	19	Los Angeles	GAC	1022	Comprehensive
106191231	LOS ANGELES COUNTY OLIVE VIEW-UCLA MEDICAL CENTER	14445 OLIVE VIEW DRIVE	SYLMAR	91342	19	Los Angeles	GAC	377	Basic
106191306	LAC/RANCHO LOS AMIGOS NATIONAL REHAB CENTER	7601 EAST IMPERIAL HIGHWAY	DOWNEY	90242	19	Los Angeles	GAC	395	
106191450	KAISER FND HOSP - WOODLAND HILLS	5601 DE SOTO AVENUE	WOODLAND HILLS	91367	19	Los Angeles	GAC	218	Basic
106194010	AMERICAN RECOVERY CENTER	2180 WEST VALLEY BOULEVARD	POMONA	91768	19	Los Angeles	CDRH	50	
106194044	BELLWOOD HEALTH CENTER	17800 WOODRUFF AVENUE	BELLFLOWER	90706	19	Los Angeles	PHF	67	
106194219	USC UNIVERSITY HOSPITAL	1500 SAN PABLO STREET	LOS ANGELES	90033	19	Los Angeles	GAC	371	
106194967	STAR VIEW ADOLESCENT - P H F	4025 WEST 226 STREET	TORRANCE	90505	19	Los Angeles	PHF	16	
106194981	LA CASA PSYCHIATRIC HEALTH FACILITY	6060 PARAMOUNT BLVD.	LONG BEACH	90805	19	Los Angeles	PHF	16	
106196035	KAISER FND HOSP - BALDWIN PARK	1011 BALDWIN PARK BLVD.	BALDWIN PARK	91706	19	Los Angeles	GAC	269	Basic
106196168	EARL AND LORRAINE MILLER CHILDRENS HOSPITAL	2801 ATLANTIC AVENUE	LONG BEACH	90806	19	Los Angeles	GAC	308	
106196404	JOYCE EISENBERG KEEFER MEDICAL CENTER	7150 TAMPA AVENUE	RESEDA	91335	19	Los Angeles	PSYCH	249	
106201281	MADERA COMMUNITY HOSPITAL	1250 EAST ALMOND AVENUE	MADERA	93637	20	Madera	GAC	106	Basic
106204019	CHILDREN'S HOSPITAL CENTRAL CALIFORNIA	9300 VALLEY CHILDREN'S PLACE	MADERA	93638	20	Madera	GAC	255	Basic
106210992	KAISER FND HOSP - SAN RAFAEL	99 MONTECILLO ROAD	SAN RAFAEL	94903	21	Marin	GAC	120	Basic
106210993	KENTFIELD REHABILITATION HOSPITAL	1125 SIR FRANCIS DRAKE BLVD.	KENTFIELD	94914-	21	Marin	GAC	60	
106211006	MARIN GENERAL HOSPITAL	250 BON AIR ROAD	GREENBRAE	94904	21	Marin	GAC	235	Basic
106214034	NOVATO COMMUNITY HOSPITAL	180 ROLAND WAY	NOVATO	94945	21	Marin	GAC	47	Basic
106220733	JOHN C FREMONT HEALTHCARE DISTRICT	5189 HOSPITAL RD., PO BOX 216	MARIPOSA	95338	22	Mariposa	GAC	34	Standby
106230949	FRANK R HOWARD MEMORIAL HOSPITAL	1 MADRONE STREET	WILLITS	95490	23	Mendocino	GAC	38	Standby
106231013	MENDOCINO COAST DISTRICT HOSPITAL	700 RIVER DRIVE	FORT BRAGG	95437	23	Mendocino	GAC	49	Standby
106231396	UKIAH VALLEY MEDICAL CENTER/HOSPITAL DRIVE	275 HOSPITAL DRIVE	UKIAH	95482	23	Mendocino	GAC	78	Basic
106240853	DOS PALOS MEMORIAL HOSPITAL	2118 MARGUERITE STREET	DOS PALOS	93620	24	Merced	GAC	29	
106240924	MEMORIAL HOSPITAL LOS BANOS	520 WEST I STREET	LOS BANOS	93635	24	Merced	GAC	48	Basic
106240942	MERCY MEDICAL CENTER MERCED-COMMUNITY CAMPUS	301 EAST 13TH STREET	MERCED	95340	24	Merced	GAC	174	Basic
106240948	MERCY MEDICAL CENTER MERCED-DOMINICAN CAMPUS	2740 M STREET	MERCED	95340	24	Merced	GAC	113	
106244027	MARIE GREEN PSYCHIATRIC CENTER - P H F	300 EAST 15TH STREET	MERCED	95340	24	Merced	PHF	16	
106250955	SURPRISE VALLEY COMMUNITY HOSPITAL	MAIN AND WASHINGTON STS, BOX 246	CEDARVILLE	96104	25	Modoc	GAC	26	Standby
106250956	MODOC MEDICAL CENTER	228 MC DOWELL STREET	ALTURAS	96101	25	Modoc	GAC	87	Standby
106260011	MAMMOTH HOSPITAL	85 SIERRA PARK ROAD	MAMMOTH LAKES	93546	26	Mono	GAC	15	Standby
106270744	COMMUNITY HOSPITAL MONTEREY PENINSULA	23625 W. R. HOLMAN HIGHWAY	MONTEREY	93940	27	Monterey	GAC	313	Basic
106270777	GEORGE L MEE MEMORIAL HOSPITAL	300 CANAL STREET	KING CITY	93930	27	Monterey	GAC	119	Basic
106270875	SALINAS VALLEY MEMORIAL HOSPITAL	450 EAST ROMIE LANE	SALINAS	93901	27	Monterey	GAC	269	Basic
106274043	NATIVIDAD MEDICAL CENTER	1441 CONSTITUTION BOULEVARD	SALINAS	93906	27	Monterey	GAC	172	Basic
106281047	QUEEN OF THE VALLEY HOSPITAL - NAPA	1000 TRANCAS STREET	NAPA	94558	28	Napa	GAC	191	Basic
106281078	ST. HELENA HOSPITAL	10 WOODLAND RD.	ST. HELENA	94574	28	Napa	GAC	181	Standby
106281266	NAPA STATE HOSPITAL	2100 NAPA-VALLEJO HIGHWAY	NAPA	94558	28	Napa	PSYCH	1362	
106281297	N M HOLDERMAN MEMORIAL HOSPITAL (VET'S HOME OF CAL	P.O. BOX 1200	YOUNTVILLE	94599	28	Napa	GAC	809	

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106291023	SIERRA NEVADA MEMORIAL HOSPITAL	155 GLASSON WAY	GRASS VALLEY	95945	29	Nevada	GAC	121	Basic
106291053	TAHOE FOREST HOSPITAL	10121 PINE STREET POB 759	TRUCKEE	96160	29	Nevada	GAC	72	Basic
106300032	CHILDREN'S HOSPITAL OF ORANGE COUNTY	455 SO. MAIN STREET	ORANGE	92668	30	Orange	GAC	220	Basic
106300225	ORANGE COAST MEMORIAL MEDICAL CENTER	9920 TALBERT AVENUE	FOUNTAIN VALLEY	92708	30	Orange	GAC	224	Basic
106301097	ANAHEIM GENERAL HOSPITAL	3350 WEST BALL ROAD	ANAHEIM	92804	30	Orange	GAC	101	Basic
106301098	ANAHEIM MEMORIAL MEDICAL CENTER	1111 WEST LA PALMA AVENUE	ANAHEIM	92801	30	Orange	GAC	223	Basic
106301109	ANAHEIM GENERAL HOSPITAL - BUENA PARK CAMPUS	5742 BEACH BOULEVARD	BUENA PARK	90621	30	Orange	GAC	42	
106301127	KINDRED HOSPITAL BREA	875 NORTH BREA BOULEVARD	BREA	92621-	30	Orange	GAC	48	
106301132	KAISER FND HOSP - ANAHEIM	441 LAKEVIEW AVENUE	ANAHEIM	92807	30	Orange	GAC	200	Basic
106301140	CHAPMAN MEDICAL CENTER	2601 EAST CHAPMAN AVENUE	ORANGE	92669	30	Orange	GAC	114	Basic
106301155	COLLEGE HOSPITAL COSTA MESA	301 VICTORIA STREET	COSTA MESA	92627	30	Orange	GAC	122	
106301167	KINDRED HOSPITAL - SANTA ANA	1901 NORTH COLLEGE AVENUE	SANTA ANA	92706	30	Orange	GAC	54	
106301175	FOUNTAIN VALLEY RGNL HOSP AND MED CTR - EUCLID	17100 EUCLID STREET	FOUNTAIN VALLEY	92708	30	Orange	GAC	293	Basic
106301188	WESTERN MEDICAL CENTER HOSPITAL - ANAHEIM	1025 SOUTH ANAHEIM BLVD.	ANAHEIM	92805	30	Orange	GAC	188	Basic
106301205	HOAG MEMORIAL HOSPITAL PRESBYTERIAN	ONE HOAG DRIVE	NEWPORT BEACH	92663	30	Orange	GAC	498	Basic
106301209	HUNTINGTON BEACH HOSPITAL	17772 BEACH BOULEVARD	HUNTINGTON BEACH	92647	30	Orange	GAC	131	Basic
106301234	LA PALMA INTERCOMMUNITY HOSPITAL	7901 WALKER STREET	LA PALMA	90623	30	Orange	GAC	141	Basic
106301248	LOS ALAMITOS MEDICAL CENTER	3751 KATELLA AVENUE	LOS ALAMITOS	90720	30	Orange	GAC	167	Basic
106301258	COASTAL COMMUNITIES HOSPITAL	2701 BRISTOL STREET	SANTA ANA	92704	30	Orange	GAC	178	Basic
106301262	MISSION HOSPITAL REGIONAL MEDICAL CENTER	27700 MEDICAL CENTER ROAD	MISSION VIEJO	92691	30	Orange	GAC	304	Basic
106301279	UNIVERSITY OF CALIFORNIA IRVINE MEDICAL CENTER	101 CITY DRIVE SOUTH	ORANGE	92668	30	Orange	GAC	449	Comprehensive
106301283	GARDEN GROVE HOSPITAL AND MEDICAL CENTER	12601 GARDEN GROVE BLVD.	GARDEN GROVE	92643-	30	Orange	GAC	167	Basic
106301297	PLACENTIA LINDA HOSPITAL	1301 NORTH ROSE DRIVE	PLACENTIA	92670	30	Orange	GAC	114	Basic
106301304	NEWPORT BAY HOSPITAL	1501 EAST 16TH STREET	NEWPORT BEACH	92663	30	Orange	PSYCH	34	
106301317	SADDLEBACK MEMORIAL MEDICAL CENTER	24451 HEALTH CENTER DRIVE	LAGUNA HILLS	92653	30	Orange	GAC	252	Basic
106301325	SADDLEBACK MEMORIAL MEDICAL CENTER - SAN CLEMENTE	654 CAMINO DE LOS MARES	SAN CLEMENTE	92673	30	Orange	GAC	73	Basic
106301337	SOUTH COAST MEDICAL CENTER	31872 COAST HIGHWAY	LAGUNA BEACH	92677	30	Orange	GAC	208	Basic
106301340	ST. JOSEPH HOSPITAL - ORANGE	1100 WEST STEWART DRIVE	ORANGE	92868	30	Orange	GAC	525	Basic
106301342	ST. JUDE MEDICAL CENTER	101 EAST VALENCIA MESA DRIVE	FULLERTON	92835	30	Orange	GAC	359	Basic
106301357	TUSTIN HOSPITAL MEDICAL CENTER	14662 NEWPORT AVENUE	TUSTIN	92680	30	Orange	GAC	177	Basic
106301379	WEST ANAHEIM MEDICAL CENTER	3033 WEST ORANGE AVENUE	ANAHEIM	92804	30	Orange	GAC	219	Basic
106301380	KINDRED HOSPITAL WESTMINSTER	200 HOSPITAL CIRCLE	WESTMINSTER	92683	30	Orange	GAC	109	
106301566	WESTERN MEDICAL CENTER - SANTA ANA	1001 NORTH TUSTIN AVENUE	SANTA ANA	92705	30	Orange	GAC	282	Basic
106301781	FAIRVIEW DEVELOPMENTAL CENTER	2501 HARBOR BOULEVARD	COSTA MESA	92626	30	Orange	GAC	1218	
106304039	FOUNTAIN VALLEY RGNL HOSP AND MED CTR - WARNER	11250 WARNER AVENUE	FOUNTAIN VALLEY	92708	30	Orange	GAC	107	
106304045	IRVINE REGIONAL HOSPITAL AND MEDICAL CENTER	16200 SAND CANYON AVENUE	IRVINE	92718	30	Orange	GAC	176	Basic
106304079	HEALTHSOUTH TUSTIN REHABILITATION HOSPITAL	14851 YORBA STREET	TUSTIN	92680	30	Orange	GAC	48	
106304113	CHILDREN'S HOSPITAL AT MISSION	27700 MEDICAL CTR. RD., 5TH FL	MISSION VIEJO	92691	30	Orange	GAC	48	Basic
106304159	HEALTHBRIDGE CHILDREN'S HOSPITAL-ORANGE	393 S, TUSTIN STREET	ORANGE	92866	30	Orange	GAC	27	
106310791	SUTTER AUBURN FAITH HOSPITAL	11815 EDUCATION STREET	AUBURN	95602	31	Placer	GAC	97	Basic
106311000	SUTTER ROSEVILLE MEDICAL CENTER	ONE MEDICAL PLAZA	ROSEVILLE	95661	31	Placer	GAC	270	Basic
106314024	KAISER FND HOSP - SACRAMENTO/ROSEVILLE-EUREKA	1600 EUREKA ROAD	ROSEVILLE	95661	31	Placer	GAC	166	Basic
106314029	TELECARE PLACER COUNTY PSYCHIATRIC HEALTH FACILITY	101 CIRBY WAY DRIVE	ROSEVILLE	95661	31	Placer	PHF	16	
106320859	EASTERN PLUMAS HOSPITAL-PORTOLA CAMPUS	500 1ST STREET	PORTOLA	96122	32	Plumas	GAC	36	Standby
106320874	INDIAN VALLEY HOSPITAL	184 HOT SPRINGS ROAD	GREENVILLE	95947	32	Plumas	GAC	26	
106320986	PLUMAS DISTRICT HOSPITAL	1065 BUCKS LAKE ROAD	QUINCY	95971	32	Plumas	GAC	26	Standby
106321016	SENECA HEALTHCARE DISTRICT	130 BRENTWOOD DRIVE	CHESTER	96020	32	Plumas	GAC	26	Standby
106330120	BETTY FORD CENTER AT EISENHOWER, THE	39000 BOB HOPE DRIVE	RANCHO MIRAGE	92270	33	Riverside	CDRH	100	
106331145	CORONA REGIONAL MEDICAL CENTER-MAGNOLIA	730 OLD MAGNOLIA AVENUE	CORONA	91720	33	Riverside	GAC	80	

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106331152	CORONA REGIONAL MEDICAL CENTER-MAIN	800 SOUTH MAIN STREET	CORONA	91720	33	Riverside	GAC	160	Basic
106331164	DESERT REGIONAL MEDICAL CENTER	1150 NORTH INDIAN CANYON DRIVE	PALM SPRINGS	92262	33	Riverside	GAC	367	Comprehensive
106331168	EISENHOWER MEMORIAL HOSPITAL	39-000 BOB HOPE DRIVE	RANCHO MIRAGE	92270	33	Riverside	GAC	289	Basic
106331194	HEMET VALLEY MEDICAL CENTER	1117 EAST DEVONSHIRE	HEMET	92543	33	Riverside	GAC	433	Basic
106331216	JOHN F KENNEDY MEMORIAL HOSPITAL	47-111 MONROE STREET	INDIO	92201	33	Riverside	GAC	145	Basic
106331226	RIVERSIDE CENTER FOR BEHAVIORAL MEDICINE	5900 BROCKTON AVENUE	RIVERSIDE	92506	33	Riverside	PSYCH	68	
106331288	PALO VERDE HOSPITAL	250 NORTH FIRST STREET	BLYTHE	92225	33	Riverside	GAC	51	Standby
106331293	PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER	3865 JACKSON STREET	RIVERSIDE	92503	33	Riverside	GAC	193	Basic
106331312	RIVERSIDE COMMUNITY HOSPITAL	4445 MAGNOLIA AVENUE	RIVERSIDE	92501	33	Riverside	GAC	373	Basic
106331326	SAN GORGONIO MEMORIAL HOSPITAL	600 HIGHLAND SPRINGS AVENUE	BANNING	92220	33	Riverside	GAC	77	Basic
106332172	VISTA HOSPITAL OF RIVERSIDE	2224 MEDICAL CENTER DRIVE	PERRIS	92571	33	Riverside	GAC	34	Basic
106334001	SOUTHWEST HEALTHCARE SYSTEM-WILDOMAR	36485 INLAND VALLEY	WILDOMAR	92595	33	Riverside	GAC	122	Basic
106334018	MENIFEE VALLEY MEDICAL CENTER	28400 MCCALL BOULEVARD	SUN CITY	92585	33	Riverside	GAC	84	Basic
106334025	KAISER FND HOSP - RIVERSIDE	10800 MAGNOLIA AVENUE	RIVERSIDE	92505	33	Riverside	GAC	215	Basic
106334048	MORENO VALLEY COMMUNITY HOSPITAL	27300 IRIS AVENUE	MORENO VALLEY	92555	33	Riverside	GAC	101	Basic
106334068	SOUTHWEST HEALTHCARE SYSTEM-MURRIETA	25500 MEDICAL CENTER DRIVE	MURRIETA	92562	33	Riverside	GAC	96	Basic
106334457	OASIS PSYCHIATRIC HEALTH FACILITY	47-915 OASIS STREET	INDIO	92201	33	Riverside	PHF	16	
106334487	RIVERSIDE COUNTY REGIONAL MEDICAL CENTER	26520 CACTUS AVENUE	MORENO VALLEY	92555	33	Riverside	GAC	439	Basic
106340913	KAISER FND HOSP - SACRAMENTO/ROSEVILLE-MORSE	2025 MORSE AVENUE	SACRAMENTO	95825	34	Sacramento	GAC	333	Basic
106340947	MERCY GENERAL HOSPITAL	4001 J STREET	SACRAMENTO	95819	34	Sacramento	GAC	342	Basic
106340950	MERCY SAN JUAN HOSPITAL	6501 COYLE AVENUE	CARMICHAEL	95608	34	Sacramento	GAC	260	Basic
106340951	METHODIST HOSPITAL OF SACRAMENTO	7500 HOSPITAL DRIVE	SACRAMENTO	95823	34	Sacramento	GAC	333	Basic
106341006	UNIVERSITY OF CALIFORNIA DAVIS MEDICAL CENTER	2315 STOCKTON BOULEVARD	SACRAMENTO	95817	34	Sacramento	GAC	577	Comprehensive
106341052	SUTTER MEMORIAL HOSPITAL	5151 F STREET	SACRAMENTO	95819	34	Sacramento	GAC	348	Basic
106342344	KAISER FND HOSP - SOUTH SACRAMENTO	6600 BRUCEVILLE ROAD	SACRAMENTO	95823	34	Sacramento	GAC	161	Basic
106342392	SIERRA VISTA HOSPITAL	8001 BRUCEVILLE ROAD	SACRAMENTO	95823	34	Sacramento	PSYCH	72	
106344011	SACRAMENTO COUNTY MENTAL HEALTH TREATMENT CENTER	2150 STOCKTON BOULEVARD	SACRAMENTO	95817	34	Sacramento	PHF	100	
106344017	SUTTER CENTER FOR PSYCHIATRY	7700 FOLSOM BOULEVARD	SACRAMENTO	95826	34	Sacramento	PSYCH	69	
106344017	SUTTER GENERAL HOSPITAL	2801 L STREET	SACRAMENTO	95816	34	Sacramento	GAC	406	Basic
106344021	HERITAGE OAKS HOSPITAL	4250 AUBURN BLVD.	SACRAMENTO	95841	34	Sacramento	PSYCH	76	
106344029	MERCY HOSPITAL - FOLSOM	1650 CREEKSIDE DRIVE	FOLSOM	95630	34	Sacramento	GAC	85	Basic
106344035	KINDRED HOSPITAL - SACRAMENTO	223 FARGO WAY	FOLSOM	95630	34	Sacramento	GAC	39	
106344114	SHRINERS HOSPITALS FOR CHILDREN NORTHERN CALIF.	2425 STOCKTON BLVD	SACRAMENTO	95817	34	Sacramento	GAC	80	
106350784	HAZEL HAWKINS MEMORIAL HOSPITAL	911 SUNSET DRIVE	HOLLISTER	95023	35	San Benito	GAC	106	Basic
106361105	BARSTOW COMMUNITY HOSPITAL	555 SOUTH 7TH AVENUE	BARSTOW	92311	36	San Bernardino	GAC	56	Basic
106361110	BEAR VALLEY COMMUNITY HOSPITAL	41870 GARSTIN DRIVE	BIG BEAR LAKE	92315	36	San Bernardino	GAC	30	Standby
106361144	CHINO VALLEY MEDICAL CENTER	5451 WALNUT AVENUE	CHINO	91710	36	San Bernardino	GAC	126	Basic
106361166	MONTCLAIR HOSPITAL MEDICAL CENTER	5000 SAN BERNARDINO STREET	MONTCLAIR	91763	36	San Bernardino	GAC	102	Basic
106361223	KAISER FND HOSP - FONTANA	9961 SIERRA AVENUE	FONTANA	92335	36	San Bernardino	GAC	440	Basic
106361245	LOMA LINDA UNIV. MED. CENTER EAST CAMPUS HOSPITAL	25333 BARTON ROAD	LOMA LINDA	92354	36	San Bernardino	GAC	113	
106361246	LOMA LINDA UNIVERSITY MEDICAL CENTER	11234 ANDERSON STREET	LOMA LINDA	92354	36	San Bernardino	GAC	709	Basic
106361266	MOUNTAINS COMMUNITY HOSPITAL	29101 HOSPITAL ROAD	LAKE ARROWHEAD	92352	36	San Bernardino	GAC	35	Standby
106361274	KINDRED HOSPITAL ONTARIO	550 NORTH MONTEREY AVENUE	ONTARIO	91764	36	San Bernardino	GAC	91	
106361308	REDLANDS COMMUNITY HOSPITAL	350 TERRACINA BOULEVARD	REDLANDS	92373	36	San Bernardino	GAC	176	Basic
106361318	SAN ANTONIO COMMUNITY HOSPITAL	999 SAN BERNARDINO ROAD	UPLAND	91786	36	San Bernardino	GAC	280	Basic
106361323	COMMUNITY HOSPITAL OF SAN BERNARDINO	1805 MEDICAL CENTER DRIVE	SAN BERNARDINO	92411	36	San Bernardino	GAC	321	Basic
106361339	ST. BERNARDINE MEDICAL CENTER	2101 NORTH WATERMAN AVENUE	SAN BERNARDINO	92404	36	San Bernardino	GAC	463	Basic
106361343	ST. MARY REGIONAL MEDICAL CENTER	18300 HIGHWAY 18	APPLE VALLEY	92307	36	San Bernardino	GAC	186	Basic
106361370	VICTOR VALLEY COMMUNITY HOSPITAL	15248 ELEVENTH STREET	VICTORVILLE	92392	36	San Bernardino	GAC	99	Basic

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106361458	COLORADO RIVER MEDICAL CENTER	1401 BAILEY AVENUE	NEEDLES	92363	36	San Bernardino	GAC	25	Basic
106361768	PATTON STATE HOSPITAL	3102 E. HIGHLAND AVENUE	PATTON	92369	36	San Bernardino	PSYCH	1287	
106362041	HI-DESERT MEDICAL CENTER	6601 WHITE FEATHER ROAD	JOSHUA TREE	92252	36	San Bernardino	GAC	179	Basic
106364014	LOMA LINDA UNIVERSITY BEHAVORIAL MEDICINE CENTER	1710 BARTON ROAD	REDLANDS	92373	36	San Bernardino	PSYCH	89	
106364050	CANYON RIDGE HOSPITAL	5353 G STREET	CHINO	91710	36	San Bernardino	PSYCH	59	
106364121	SUN HEALTH ROBERT H. BALLARD REHABILITATION HOSP	1760 WEST 16TH STREET	SAN BERNARDINO	92411	36	San Bernardino	CDRH	60	
106364144	DESERT VALLEY HOSPITAL	16850 BEAR VALLEY ROAD	VICTORVILLE	92392	36	San Bernardino	GAC	83	Basic
106364188	RANCHO SPECIALTY HOSPITAL	10841 WHITE OAK AVENUE	RANCHO CUCAMONGA	91730	36	San Bernardino	GAC	55	
106364231	ARROWHEAD REGIONAL MEDICAL CENTER	400 N. PEPPER AVENUE	COLTON	92324-	36	San Bernardino	GAC	373	Basic
106370652	ALVARADO HOSPITAL	6655 ALVARADO ROAD	SAN DIEGO	92120-	37	San Diego	GAC	226	Basic
106370658	SCRIPPS MERCY HOSPITAL - CHULA VISTA	435 H STREET	CHULA VISTA	91910	37	San Diego	GAC	183	Basic
106370673	CHILDREN'S HOSPITAL - SAN DIEGO	3020 CHILDREN'S WAY	SAN DIEGO	92123	37	San Diego	GAC	307	Basic
106370689	SHARP CORONADO HOSPITAL AND HEALTHCARE CENTER	250 PROSPECT PLACE	CORONADO	92118	37	San Diego	GAC	204	Basic
106370693	SHARP CABRILLO HOSPITAL	3475 KENYON STREET	SAN DIEGO	92110	37	San Diego	GAC	180	
106370694	SHARP MEMORIAL HOSPITAL	7901 FROST STREET	SAN DIEGO	92123	37	San Diego	GAC	341	Basic
106370695	SHARP MARY BIRCH HOSPITAL FOR WOMEN	3003 HEALTH CENTER DRIVE	SAN DIEGO	92123	37	San Diego	GAC	169	
106370705	FALLBROOK HOSPITAL DISTRICT	624 EAST ELDER STREET	FALLBROOK	92028	37	San Diego	GAC	140	Basic
106370714	GROSSMONT HOSPITAL	5555 GROSSMONT CENTER DRIVE	LA MESA	91942	37	San Diego	GAC	481	Basic
106370721	KINDRED HOSPITAL - SAN DIEGO	1940 EL CAJON BOULEVARD	SAN DIEGO	92104-	37	San Diego	GAC	70	
106370730	KAISER FND HOSP - SAN DIEGO	4647 ZION AVENUE	SAN DIEGO	92120	37	San Diego	GAC	392	Basic
106370744	SCRIPPS MERCY HOSPITAL	4077 FIFTH AVENUE	SAN DIEGO	92103-	37	San Diego	GAC	517	Basic
106370745	SHARP MESA VISTA HOSPITAL	7850 VISTA HILL AVENUE	SAN DIEGO	92123	37	San Diego	PSYCH	149	
106370749	ALVARADO PARKWAY INSTITUTE B.H.S.	7050 PARKWAY DRIVE	LA MESA	91942	37	San Diego	PSYCH	66	
106370755	PALOMAR MEDICAL CENTER	555 E. VALLEY PARKWAY	ESCONDIDO	92025	37	San Diego	GAC	420	Basic
106370759	PARADISE VALLEY HOSPITAL	2400 EAST FOURTH STREET	NATIONAL CITY	92050	37	San Diego	GAC	301	Basic
106370771	SCRIPPS MEMORIAL HOSPITAL - LA JOLLA	9888 GENESEE AVENUE	LA JOLLA	92037	37	San Diego	GAC	307	Basic
106370780	TRI-CITY MEDICAL CENTER	4002 VISTA WAY	OCEANSIDE	92056	37	San Diego	GAC	397	Basic
106370782	UNIVERSITY OF CALIF-SAN DIEGO MEDICAL CENTER	200 WEST ARBOR DRIVE	SAN DIEGO	92103	37	San Diego	GAC	421	Comprehensive
106370787	PROMISE HOSPITAL OF SAN DIEGO	5550 UNIVERSITY AVENUE	SAN DIEGO	92105	37	San Diego	GAC	100	
106370875	SHARP CHULA VISTA MEDICAL CENTER	751 MEDICAL CENTER COURT	CHULA VISTA	91911	37	San Diego	GAC	330	Basic
106370977	POMERADO HOSPITAL	15615 POMERADO ROAD	POWAY	92064	37	San Diego	GAC	236	Basic
106371256	SCRIPPS GREEN HOSPITAL	10666 NORTH TORREY PINES ROAD	LA JOLLA	92037	37	San Diego	GAC	173	
106371394	SCRIPPS MEMORIAL HOSPITAL - ENCINITAS	354 SANTA FE DRIVE	ENCINITAS	92024	37	San Diego	GAC	138	Basic
106374024	AURORA SAN DIEGO	11878 AVENUE OF INDUSTRY	SAN DIEGO	92128	37	San Diego	PSYCH	80	
106374049	SHARP VISTA PACIFICA	7989 LINDA VISTA ROAD	SAN DIEGO	92111	37	San Diego	CDRH	16	
106374055	SAN DIEGO COUNTY PSYCHIATRIC HOSPITAL	3851 ROSECRANS STREET	SAN DIEGO	92110	37	San Diego	PSYCH	369	
106374063	ALVARADO HOSPITAL	6645 ALVARADO ROAD	SAN DIEGO	92120	37	San Diego	GAC	80	
106374084	SAN DIEGO HOSPICE AND PALLIATIVE CARE-ACUTE CARE CTR	4311 THIRD AVENUE	SAN DIEGO	92103	37	San Diego	PSYCH	24	
106374094	CONTINENTAL REHABILITATION HOSPITAL OF SAN DIEGO	555 WASHINGTON STREET	SAN DIEGO	92103	37	San Diego	GAC	110	
106374141	UCSD-LA JOLLA, JOHN M & SALLY B. THORNTON HOSPITAL	9300 CAMPUS POINT DRIVE	LA JOLLA	92037	37	San Diego	GAC	119	Basic
106380777	CALIFORNIA PACIFIC MED CTR-CALIFORNIA WEST	3700 CALIFORNIA STREET	SAN FRANCISCO	94118	38	San Francisco	GAC	299	
106380826	CALIFORNIA PACIFIC MED CTR-CALIFORNIA EAST	3773 SACRAMENTO STREET	SAN FRANCISCO	94118	38	San Francisco	GAC	101	
106380842	JEWISH HOME	302 SILVER AVENUE	SAN FRANCISCO	94112-	38	San Francisco	PSYCH	491	
106380857	KAISER FND HOSP - GEARY S F	2425 GEARY BOULEVARD	SAN FRANCISCO	94115	38	San Francisco	GAC	247	Basic
106380865	LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER	375 LAGUNA HONDA BOULEVARD	SAN FRANCISCO	94116	38	San Francisco	GAC	1457	
106380868	LANGLEY PORTER PSYCHIATRIC INSTITUTE	401 PARNASSUS AVENUE	SAN FRANCISCO	94143	38	San Francisco	PSYCH	67	
106380895	UCSF MEDICAL CENTER AT MOUNT ZION	1600 DIVISADERO STREET	SAN FRANCISCO	94115	38	San Francisco	GAC	140	
106380929	CALIFORNIA PACIFIC MED CTR-PACIFIC CAMPUS	2333 BUCHANAN STREET	SAN FRANCISCO	94115	38	San Francisco	GAC	313	Basic
106380933	CALIFORNIA PACIFIC MED CTR-DAVIES CAMPUS	CASTRO AND DUBOCE STREETS	SAN FRANCISCO	94114	38	San Francisco	GAC	311	Basic

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106380939	SAN FRANCISCO GENERAL HOSPITAL	1001 POTRERO AVENUE	SAN FRANCISCO	94110	38	San Francisco	GAC	598	Comprehensive
106380960	ST. FRANCIS MEMORIAL HOSPITAL	900 HYDE STREET	SAN FRANCISCO	94109	38	San Francisco	GAC	356	Basic
106380964	ST. LUKE'S HOSPITAL	3555 CESAR CHAVEZ STREET	SAN FRANCISCO	94110	38	San Francisco	GAC	260	Basic
106380965	ST. MARY'S MEDICAL CENTER, SAN FRANCISCO	450 STANYAN STREET	SAN FRANCISCO	94117	38	San Francisco	GAC	403	Basic
106381154	UCSF MEDICAL CENTER	505 PARNASSUS AVENUE	SAN FRANCISCO	94122	38	San Francisco	GAC	566	Basic
106382715	CHINESE HOSPITAL	845 JACKSON STREET	SAN FRANCISCO	94133	38	San Francisco	GAC	54	Standby
106390846	DAMERON HOSPITAL	525 WEST ACACIA	STOCKTON	95203	39	San Joaquin	GAC	188	Basic
106390922	LODI MEMORIAL HOSPITAL - WEST	800 SO. LOWER SACRAMENTO ROAD	LODI	95242-	39	San Joaquin	GAC	71	
106390923	LODI MEMORIAL HOSPITAL	975 SOUTH FAIRMONT AVENUE	LODI	95240-	39	San Joaquin	GAC	107	Basic
106391010	SAN JOAQUIN GENERAL HOSPITAL	500 WEST HOSPITAL ROAD	FRENCH CAMP	95231	39	San Joaquin	GAC	196	Basic
106391042	ST. JOSEPH'S MEDICAL CENTER OF STOCKTON	1800 NORTH CALIFORNIA STREET	STOCKTON	95204	39	San Joaquin	GAC	294	Basic
106391056	SUTTER TRACY COMMUNITY HOSPITAL	1420 NORTH TRACY BOULEVARD	TRACY	95376	39	San Joaquin	GAC	82	Basic
106392232	ST. JOSEPH'S BEHAVIORAL HEALTH CENTER	2510 NORTH CALIFORNIA STREET	STOCKTON	95204	39	San Joaquin	PSYCH	35	
106392287	DOCTORS HOSPITAL OF MANTECA	1205 EAST NORTH STREET	MANTECA	95336	39	San Joaquin	GAC	73	Basic
106394003	SAN JOAQUIN COUNTY P.H.F.	1212 NORTH CALIFORNIA	STOCKTON	95202	39	San Joaquin	PHF	40	
106394009	KAISER FND HOSP-MANTECA	1777 WEST YOSEMITE AVENUE	MANTECA	95336	39	San Joaquin	GAC	99	Basic
106400466	ARROYO GRANDE COMMUNITY HOSPITAL	345 SOUTH HALCYON ROAD	ARROYO GRANDE	93420	40	San Luis Obispo	GAC	65	Basic
106400480	FRENCH HOSPITAL MEDICAL CENTER	1911 JOHNSON AVENUE	SAN LUIS OBISPO	93401	40	San Luis Obispo	GAC	112	Basic
106400524	SIERRA VISTA REGIONAL MEDICAL CENTER	1010 MURRAY STREET	SAN LUIS OBISPO	93405	40	San Luis Obispo	GAC	165	Basic
106400548	TWIN CITIES COMMUNITY HOSPITAL	1100 LAS TABLAS ROAD	TEMPLETON	93465	40	San Luis Obispo	GAC	114	Basic
106400683	ATASCADERO STATE HOSPITAL	P O BOX 7001	ATASCADERO	93423	40	San Luis Obispo	PSYCH	1275	
106404046	SAN LUIS OBISPO CO PSYCHIATRIC HEALTH FACILITY	2178 JOHNSON AVE	SAN LUIS OBISPO	93401	40	San Luis Obispo	PHF	16	
106410742	MILLS HEALTH CENTER	100 SOUTH SAN MATEO DRIVE	SAN MATEO	94401	41	San Mateo	GAC	40	Standby
106410782	SAN MATEO MEDICAL CENTER	222 WEST 39TH AVENUE	SAN MATEO	94403	41	San Mateo	GAC	509	Basic
106410804	KAISER FND HOSP - REDWOOD CITY	1150 VETERANS BOULEVARD	REDWOOD CITY	94063	41	San Mateo	GAC	213	Basic
106410806	KAISER FND HOSP - SOUTH SAN FRANCISCO	1200 EL CAMINO REAL	SOUTH SAN FRANCISCO	94080	41	San Mateo	GAC	120	Basic
106410817	SETON MEDICAL CENTER	1900 SULLIVAN AVENUE	DALY CITY	94015	41	San Mateo	GAC	357	Basic
106410828	SETON MEDICAL CENTER - COASTSIDE	600 MARINE BOULEVARD	MOSS BEACH	94038	41	San Mateo	GAC	121	Standby
106410852	PENINSULA MEDICAL CENTER	1783 EL CAMINO REAL	BURLINGAME	94010	41	San Mateo	GAC	363	Basic
106410891	SEQUOIA HOSPITAL	170 ALAMEDA DE LAS PULGAS	REDWOOD CITY	94062	41	San Mateo	GAC	313	Basic
106414018	MENLO PARK SURGICAL HOSPITAL	570 WILLOW ROAD	MENLO PARK	94025	41	San Mateo	GAC	16	
106420483	GOLETA VALLEY COTTAGE HOSPITAL	351 SOUTH PATTERSON AVENUE	SANTA BARBARA	93111	42	Santa Barbara	GAC	122	Basic
106420491	LOMPOC HEALTHCARE DISTRICT	508 EAST HICKORY	LOMPOC	93436	42	Santa Barbara	GAC	170	Basic
106420493	MARIAN MEDICAL CENTER	1400 EAST CHURCH STREET	SANTA MARIA	93454	42	Santa Barbara	GAC	262	Basic
106420514	SANTA BARBARA COTTAGE HOSPITAL	320 WEST PUEBLO STREET	SANTA BARBARA	93105	42	Santa Barbara	GAC	370	Basic
106420522	SANTA YNEZ VALLEY COTTAGE HOSPITAL	700 ALAMO PINTADO ROAD	SOLVANG	93463	42	Santa Barbara	GAC	20	Standby
106424002	SANTA BARBARA COUNTY P.H.F.	315 CAMINO DEL REMEDIO	SANTA BARBARA	93110	42	Santa Barbara	PHF	16	
106424047	REHABILITATION INSTITUTE AT SANTA BARBARA	2415 DE LA VINA	SANTA BARBARA	93105	42	Santa Barbara	CDRH	38	
106430705	REGIONAL MEDICAL OF SAN JOSE	225 NORTH JACKSON AVENUE	SAN JOSE	95116	43	Santa Clara	GAC	204	Basic
106430743	COMMUNITY HOSPITAL OF LOS GATOS	815 POLLARD ROAD	LOS GATOS	95032	43	Santa Clara	GAC	143	Basic
106430763	EL CAMINO HOSPITAL	2500 GRANT ROAD	MOUNTAIN VIEW	94040	43	Santa Clara	GAC	395	Basic
106430779	GOOD SAMARITAN HOSPITAL-SAN JOSE	2425 SAMARITAN DRIVE	SAN JOSE	95124	43	Santa Clara	GAC	359	Basic
106430837	O'CONNOR HOSPITAL - SAN JOSE	2105 FOREST AVENUE	SAN JOSE	95128	43	Santa Clara	GAC	358	Basic
106430883	SANTA CLARA VALLEY MEDICAL CENTER	751 SOUTH BASCOM AVENUE	SAN JOSE	95128-	43	Santa Clara	GAC	574	Comprehensive
106430905	STANFORD HOSPITAL	300 PASTEUR DRIVE	PALO ALTO	94305	43	Santa Clara	GAC	613	Basic
106430915	MISSION OAKS HOSPITAL	15891 LOS GATOS-ALMADEN ROAD	LOS GATOS	95032	43	Santa Clara	GAC	70	
106431013	AGNEWS STATE HOSPITAL	3500 ZANKER ROAD	SAN JOSE	95134-	43	Santa Clara	GAC	919	
106431506	KAISER FND HOSP - SANTA TERESA COMMUNITY HOSPITAL	250 HOSPITAL PARKWAY	SAN JOSE	95119	43	Santa Clara	GAC	248	Basic
106434040	LUCILE SALTER PACKARD CHILDREN'S HOSP. AT STANFORD	725 WELCH ROAD	PALO ALTO	94304	43	Santa Clara	GAC	264	

OSHPD ID	Name	Location Address	City	Zip	County No	County Name	Type	Beds	EMS Level
106434051	CHILDRENS RECOVERY CENTER OF NORTHERN CALIFORNIA	3777 SOUTH BASCOM AVENUE	CAMPBELL	95008	43	Santa Clara	GAC	29	
106434138	ST. LOUISE REGIONAL HOSPITAL	9400 NO NAME UNO	GILROY	95020	43	Santa Clara	GAC	93	Basic
106434153	KAISER SANTA CLARA MEDICAL CENTER	700 LAWRENCE EXPRESSWAY	SANTA CLARA	95051	43	Santa Clara	GAC	327	Basic
106440755	DOMINICAN HOSPITAL-SANTA CRUZ/SOQUEL	1555 SOQUEL DRIVE	SANTA CRUZ	95065	44	Santa Cruz	GAC	268	Basic
106441807	DOMINICAN HOSPITAL-SANTA CRUZ/FREDERICK	610 FREDERICK STREET	SANTA CRUZ	95062	44	Santa Cruz	GAC	111	
106444012	SUTTER MATERNITY AND SURGERY CENTER OF SANTA CRUZ	2900 CHANTICLEER AVENUE	SANTA CRUZ	95065	44	Santa Cruz	GAC	30	
106444013	WATSONVILLE COMMUNITY HOSPITAL	75 NIELSON STREET	WATSONVILLE	95076	44	Santa Cruz	GAC	106	Basic
106450936	MAYERS MEMORIAL HOSPITAL	HWY. 299-E, P O BOX 459	FALL RIVER MILLS	96028	45	Shasta	GAC	121	Standby
106450940	SHASTA REGIONAL MEDICAL CENTER	1100 BUTTE STREET	REDDING	96049-	45	Shasta	GAC	246	Basic
106450949	MERCY MEDICAL CENTER	2175 ROSALINE AVENUE	REDDING	96001	45	Shasta	GAC	273	Basic
106451019	SHASTA COUNTY P H F	2640 BRESLAUER WAY	REDDING	96001	45	Shasta	PHF	15	
106454012	NORTHERN CALIFORNIA REHABILITATION HOSPITAL	2801 EUREKA WAY	REDDING	96001	45	Shasta	GAC	88	
106454013	PATIENTS' HOSPITAL OF REDDING	2900 EUREKA WAY	REDDING	96001	45	Shasta	GAC	10	
106461024	EASTERN PLUMAS HOSPITAL-LOYALTON CAMPUS	700 THIRD STREET	LOYALTON	96118	46	Sierra	GAC	40	
106470871	MERCY MEDICAL CENTER MT. SHASTA	914 PINE STREET, BOX 239	MOUNT SHASTA	96067	47	Siskiyou	GAC	80	Basic
106474007	FAIRCHILD MEDICAL CENTER	444 BRUCE STREET	YREKA	96097	47	Siskiyou	GAC	28	Basic
106480989	KAISER FND HOSP - REHABILITATION CENTER VALLEJO	975 SERENO DRIVE	VALLEJO	94590	48	Solano	GAC	287	Basic
106481015	ST. HELENA HOSPITAL CENTER FOR BEHAVIORAL HEALTH	525 OREGON STREET	VALLEJO	94590	48	Solano	PSYCH	61	
106481094	SUTTER SOLANO MEDICAL CENTER	300 HOSPITAL DRIVE	VALLEJO	94590	48	Solano	GAC	111	Basic
106481357	NORTH BAY MEDICAL CENTER	1200 B. GALE WILSON BLVD.	FAIRFIELD	94533	48	Solano	GAC	140	Basic
106484001	NORTH BAY VACAVALLEY HOSPITAL	1000 NUT TREE ROAD	VACAVILLE	95687	48	Solano	GAC	50	Basic
106484028	TELECARE SOLANO PSYCHIATRIC HEALTH FACILITY	2101 COURAGE DRIVE	FAIRFIELD	94533	48	Solano	PHF	16	
106490907	SANTA ROSA MEMORIAL HOSPITAL-SOTOYOME	151 SOTOYOME STREET	SANTA ROSA	95405	49	Sonoma	GAC	60	
106490919	SUTTER MEDICAL CENTER OF SANTA ROSA-CHANATE CAMPUS	3325 CHANATE ROAD	SANTA ROSA	95404	49	Sonoma	GAC	145	Basic
106490964	HEALDSBURG DISTRICT HOSPITAL	1375 UNIVERSITY STREET	HEALDSBURG	95448	49	Sonoma	GAC	43	Standby
106491001	PETALUMA VALLEY HOSPITAL	400 NORTH MC DOWELL BOULEVARD	PETALUMA	94954	49	Sonoma	GAC	80	Basic
106491064	SANTA ROSA MEMORIAL HOSPITAL-MONTGOMERY	1165 MONTGOMERY DRIVE	SANTA ROSA	95405	49	Sonoma	GAC	209	Basic
106491076	SONOMA VALLEY HOSPITAL	347 ANDRIEUX STREET	SONOMA	95476	49	Sonoma	GAC	83	Basic
106491103	SUTTER MEDICAL CENTER OF SANTA ROSA-WARRACK CAMPUS	2449 SUMMERFIELD ROAD	SANTA ROSA	95405	49	Sonoma	GAC	63	
106491267	SONOMA DEVELOPMENTAL CENTER	P.O. BOX 1493	ELDRIDGE	95431	49	Sonoma	GAC	1413	
106491338	PALM DRIVE HOSPITAL	501 PETALUMA AVENUE	SEBASTOPOL	95472	49	Sonoma	GAC	72	Standby
106494019	KAISER FND HOSP - SANTA ROSA	401 BICENTENNIAL WAY	SANTA ROSA	95403	49	Sonoma	GAC	117	Basic
106494047	WOODLANDS PSYCHIATRIC HEALTH FACILITY	21640 POCKET RANCH ROAD	GEYSERVILLE	95441	49	Sonoma	PHF	8	
106494048	SANTA ROSA MEMORIAL HOSPITAL-FULTON	1287 FULTON ROAD	SANTA ROSA	95401	49	Sonoma	GAC	76	
106500852	DOCTORS MEDICAL CENTER	1441 FLORIDA AVENUE	MODESTO	95350	50	Stanislaus	GAC	398	Basic
106500867	EMANUEL MEDICAL CENTER, INC	825 DELBON AVENUE	TURLOCK	95380	50	Stanislaus	GAC	366	Basic
106500939	MEMORIAL HOSPITAL MEDICAL CENTER - MODESTO	1700 COFFEE ROAD	MODESTO	95355	50	Stanislaus	GAC	423	Basic
106500954	KINDRED HOSPITAL MODESTO	730 17TH STREET	MODESTO	95354	50	Stanislaus	GAC	100	
106500967	OAK VALLEY DISTRICT HOSPITAL (2-RH)	350 SOUTH OAK STREET	OAKDALE	95361	50	Stanislaus	GAC	150	Basic
106501016	STANISLAUS BEHAVIORAL HEALTH CENTER	1501 CLAUS ROAD	MODESTO	95355	50	Stanislaus	GAC	67	
106504038	STANISLAUS SURGICAL HOSPITAL	1421 OAKDALE ROAD	MODESTO	95355	50	Stanislaus	GAC	23	
106510882	FREMONT MEDICAL CENTER	970 PLUMAS STREET	YUBA CITY	95991	51	Sutter	GAC	132	
106514001	SUTTER-YUBA PSYCHIATRIC HEALTH FACILITY	1965 LIVE OAK BOULEVARD	YUBA CITY	95991	51	Sutter	PHF	18	
106514033	NORTH VALLEY BEHAVIORAL HEALTH	1535 Plumas Court	Yuba City	95993	51	Sutter	PHF	16	
106514037	SEQUOIA PSYCHIATRIC CENTER - PHF	1541 Plumas Court	Yuba City	95991	51	Sutter	PHF	16	
106521041	ST. ELIZABETH COMMUNITY HOSPITAL	2550 SISTER MARY COLUMBA DRIVE	RED BLUFF	96080	52	Tehama	GAC	76	Basic
106531059	TRINITY HOSPITAL	60 EASTER AVENUE	WEAVERVILLE	96093	53	Trinity	GAC	51	Standby
106540734	KAWEAH DELTA DISTRICT HOSPITAL	400 WEST MINERAL KING	VISALIA	93291	54	Tulare	GAC	427	Basic
106540798	SIERRA VIEW DISTRICT HOSPITAL	465 WEST PUTNAM AVENUE	PORTERVILLE	93257	54	Tulare	GAC	163	Basic

Office of Statewide Health Planning and Development
Healthcare Information Division
Healthcare Information Resource Center

California Hospital
Licensed as of 12/31/07

Footnotes on Final Page

OSHPD ID	Name	Location Address	City	Zip	County No	County Name	Type	Beds	EMS Level
106540816	TULARE DISTRICT HOSPITAL	869 CHERRY AVENUE	TULARE	93274	54	Tulare	GAC	116	Basic
106541123	PORTERVILLE DEVELOPMENTAL CENTER	26501 AVENUE 140	PORTERVILLE	93258	54	Tulare	GAC	1210	
106544009	KAWEAH DELTA MENTAL HEALTH HOSPITAL D/P APH	1100 SO. AKERS STREET	VISALIA	93277	54	Tulare	GAC	63	
106551034	SONORA REGIONAL MEDICAL CENTER - FOREST	ONE SOUTH FOREST ROAD	SONORA	95370	55	Tuolumne	GAC	28	
106551061	TUOLUMNE GENERAL MEDICAL FACILITY	101 EAST HOSPITAL ROAD	SONORA	95370	55	Tuolumne	GAC	79	
106552209	SONORA REGIONAL MEDICAL CENTER - FAIRVIEW	179 SOUTH FAIRVIEW LANE	SONORA	95370	55	Tuolumne	GAC	12	
106554011	SONORA REGIONAL MEDICAL CENTER - GREENLEY	1000 Greenley Road	Sonora	95370	55	Tuolumne	GAC	140	Basic
106560203	AURORA VISTA DEL MAR HOSPITAL	801 SENECA STREET	VENTURA	93001	56	Ventura	PSYCH	87	
106560473	COMMUNITY MEMORIAL HOSPITAL-SAN BUENAVENTURA	LOMA VISTA AT BRENT STREET	VENTURA	93003	56	Ventura	GAC	242	Basic
106560481	VENTURA COUNTY MEDICAL CENTER	3291 LOMA VISTA ROAD	VENTURA	93003	56	Ventura	GAC	223	Basic
106560492	LOS ROBLES HOSPITAL & MEDICAL CENTER	215 WEST JANSS ROAD	THOUSAND OAKS	91360	56	Ventura	GAC	204	Basic
106560501	OJAI VALLEY COMMUNITY HOSPITAL	1306 MARICOPA HIGHWAY	OJAI	93023	56	Ventura	GAC	103	Standby
106560508	ST. JOHN'S PLEASANT VALLEY HOSPITAL	2309 ANTONIO AVENUE	CAMARILLO	93010	56	Ventura	GAC	180	Basic
106560521	SANTA PAULA HOSPITAL	825 NORTH 10TH STREET	SANTA PAULA	93060	56	Ventura	GAC	49	Basic
106560525	SIMI VALLEY HOSPITAL AND HEALTH CARE SVCS-SYCAMORE	2975 NORTH SYCAMORE DRIVE	SIMI VALLEY	93065	56	Ventura	GAC	185	Basic
106560529	ST. JOHN'S REGIONAL MEDICAL CENTER	1600 NORTH ROSE AVENUE	OXNARD	93030	56	Ventura	GAC	265	Basic
106560838	PACIFIC SHORES HOSPITAL	2130 VENTURA ROAD	OXNARD	93030	56	Ventura	PSYCH	30	
106564018	LOS ROBLES HOSPITAL & MEDICAL CENTER - EAST CAMPUS	150 VIA MERIDA	WESTLAKE VILAGE	91362	56	Ventura	GAC	69	
106564121	THOUSAND OAKS SURGICAL HOSPITAL	401 ROLLING OAKS DRIVE	THOUSAND OAKS	91361	56	Ventura	GAC	21	
106571086	WOODLAND MEMORIAL HOSPITAL	1325 COTTONWOOD STREET	WOODLAND	95695	57	Yolo	GAC	108	Basic
106574010	SUTTER DAVIS HOSPITAL	2000 SUTTER PLACE	DAVIS	95616	57	Yolo	GAC	48	Basic
106580996	RIDEOUT MEMORIAL HOSPITAL	726 FOURTH ST., P.O.BOX 231	MARYSVILLE	95901	58	Yuba	GAC	149	Basic
206190788	LITTLE CO OF MARY SUBACUTE CARE CTR-SOUTH BAY	3620 WEST LOMITA BOULEVARD	TORRANCE	90505	19	Los Angeles	GAC	200	Basic
206351814	HAZEL HAWKINS CONVALESCENT HOSPITAL - SUNSET	900 SUNSET DRIVE	HOLLISTER	95023	35	San Benito	GAC	70	Basic

FOOTNOTES:

Hospital Types:
GAC = Genreral Acute Care
CDRH = Chemical Dependency Recovery Hospital
PHF = Psychiatric Health Facility
PSYCH = Acute Psychiatric Facility

Licensed Emergency Medical Service (EMS) Levels:
Standby Physician On-call
Basic Physicain in EMS 24x7
Comp Physicain in EMS 24x7, plus must have in hospital 24x7, thoracic surgeon, neurosurgeon, orthopeadic surgeon, pediatrician, etc., plus they must also provide Burn, Acute Dialysis, Cardio Vascular Surgery Services, etc.

*Hospital Facility List includes license facilities in suspense.
*Hospital Facility List displays all separate locations on consolidated hospital licenses, including consolidated Nursing Homes.
*Hospital Facility List includes both community and state hospitals.
OSHPD ID that starts with:
106 = Community Based
706 = State

Department of Managed Health Care
List of All Licensed Plans

Alphabetical Report

Plan Name / Dba1 / Street Address / Mailing Address	Contact Person / Title / Phone Number / FAX Number	File No. \ Plan ID / Date Licensed / Type / Location of Files	License Counsel / Medical Survey Analyst / Examiner / Contact E-mail Address
933 0318 - Access Dental Plan	Terri Abbaszadeh	933 0318	Crystal Chen
	Vice President, Plan Administrator	12/22/1993	Marie Broadnax
8890 Cal Center Drive; Sacramento, CA 95826	916 563-6020	Dental	Jessica Tran
8890 Cal Center Drive; Sacramento, CA 95826	916 646-9000	Sacramento	terri@premierlife.com
933 0407 - ACN Group of California, Inc.	Stephen Castro	933 0407	Marie Eppler
	President and CEO	08/22/2003	Van Vu
3111 Camino Del Rio North, Suite 1000; San Diego, CA 92108	619-641-7100	Chiropractic	Lorilee Ambrosini
3111 Camino Del Rio North, Suite 1000; San Diego, CA 92108	619-641-7185	Sacramento	scastro@acngroup.com
933 0313 - Aetna Dental of California Inc.	Mary V. Anderson	933 0313	Crystal Chen
F: Aetna U.S. Healthcare Dental Plan of CA Inc,	Western Region Gen. Counsel	09/30/1993	Randi Wise
2545 W. Hillcrest Drive, Bldg. C; Thousand Oaks, CA 91320	925 948-4207	Dental	Evan Lo
2625 Shadelands Drive; Walnut Creek, CA 94598		Sacramento	AndersonMV@aetna.com
933 0176 - Aetna Health of California, Inc.	Mary V. Anderson	933 0176	Marie Eppler
F: Aetna U.S. Healthcare of California, Inc.	Western Region Gen. Counsel	08/06/1981	Randi Wise
2625 Shadelands Drive; Walnut Creek, CA 94598	925 948-4207	Full Service	Evan Lo
2625 Shadelands Drive; Walnut Creek, CA 94598	925-948-4210	Sacramento	andersonmv@aetna.com

1 Indicates: Limited License
2 Indicates: Applied for Surrender of License

Plan Name / Dba1 / Street Address / Mailing Address	Contact Person / Title / Phone Number / FAX Number	File No. \ Plan ID / Date Licensed / Type / Location of Files	License Counsel / Medical Survey Analyst / Examiner / Contact E-mail Address
933 0450 - Affinity Dental Health Plan	Alexander Gladkov	933 0450	Crystal Chen
	CEO/President	03/30/2007	Wendy Jang
6035 Bristol Parkway, Suite 200; Culver City, CA 90230	866-960-2347	Dental	Jessica Tran
6035 Bristol Parkway, Suite 200; Culver City, CA 90230	888-492-2900		affinitydentalplan@yahoo.com
933 0432 - AIDS Healthcare Foundation	Peter Reis	933 0432	Kathleen Mc Knight
Positive Healthcare	Vice President	12/01/2005	Patrick Bober
6255 W. Sunset Blvd., Ste 2100; Los Angeles, CA 90028	323-860-5235	Full Service	Maryam Tahriri
6255 W. Sunset Blvd., Ste 2100; Los Angeles, CA 90028	323-962-8513		peter.reis@aidshealth.org
933 0328 - Alameda Alliance For Health	Ingrid Lamirault	933 0328	Kathleen Mc Knight
	Chief Executive Officer	09/19/1995	Anne Potter
1240 South Loop Road; Alameda, CA 94502	510 747-4532	Full Service	Anna Belmont
1240 South Loop Road; Alameda, CA 94502	510 747-4503	Sacramento	ilamirault@alamedaalliance.com
933 0440 - Alameda Alliance Joint Powers Authority (QIF)	Ingrid Lamirault	933 0440	Kathleen Mc Knight
	Chief Executive Officer	12/01/2005	
1240 South Loop Road; Alameda, CA 94502	510-747-4532	QIF	Anna Belmont
1240 South Loop Road; Alameda, CA 94502	510-747-4503	Sacramento	ilamirault@alamedaalliance.com

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Department of Managed Health Care
List of All Licensed Plans

Alphabetical Report

Plan Name Dba1 Street Address Mailing Address	Contact Person Title Phone Number FAX Number	File No. \ Plan ID Date Licensed Type Location of Files	License Counsel Medical Survey Analyst Examiner Contact E-mail Address
933 0195 - American Healthguard Corporation	David Kutner	933 0195	Crystal Chen
dba: Centaguard Dental Plan	President	09/28/1984	Wendy Jang
30 E. Santa Clara, Suite D; Arcadia, CA 91006	626 821-5500	Dental	Jefferey Roskelley
30 E. Santa Clara, Suite D; Arcadia, CA 91006	626 821-5514	Sacramento	
933 0315 - American Specialty Health Plans, Inc.	Robert White	933 0315	Marie Eppler
dba: ASHP	Chief Operations Officer	09/02/1994	Van Vu
777 Front Street; San Diego, CA 92101	619 578-2000	Chiropractic	Hung Truong
777 Front Street; San Diego, CA 92101	619 237-3808	Sacramento	RobertW@ashn.com
933 0441 - Arta Medicare Health Plan, Inc.	Baruch Fogel	933 0441	Lily Donn
Arta	President/Chief Executive Officer	03/17/2006	Patrick Bober
3333 Michelson Drive, Suite 750; Irvine, CA 92612	949-260-6520	Full Service	Maryam Tahriri
3333 Michelson Drive, Suite 750; Irvine, CA 92612	949-567-0216	Sacramento	bfogel@1wmm.com
933 0397 - Avante Behavioral Health Plan	D. Duane Oswald	933 0397	Elaine Paniewski
	President/CEO	10/18/2000	Susan Burger
1111 East Herndon Ave., Suite 308; Fresno, CA 93720	559 261-9060	Psychological	Barbara Yaklin
1111 East Herndon Ave., Suite 308; Fresno, CA 93720	559 261-9073	Sacramento	doswald@avantehealth.com

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Department of Managed Health Care
List of All Licensed Plans

Alphabetical Report

Plan Name / Dba1 / Street Address / Mailing Address	Contact Person / Title / Phone Number / FAX Number	File No. \ Plan ID / Date Licensed / Type / Location of Files	License Counsel / Medical Survey Analyst / Examiner / Contact E-mail Address
933 0399 - BASIC CHIROPRACTIC HEALTH PLAN	David P. Moscovic	933 0399	Marie Eppler
	CFO	09/18/2001	Van Vu
2027 Grand Canal Blvd., Suite 20; Stockton, CA 95207	209 476-1435	Chiropractic	Nelly Wei
2027 Grand Canal Blvd., Suite 19; Stockton, CA 95207		Sacramento	david@bchpinc.com
933 0303 - Blue Cross of California	Judy Vaccaro	933 0303	Katie Coyne
Anthem Blue Cross	Senior Managing Counsel	01/07/1993	James Hollister
1 Wellpoint Way; Thousand Oaks, CA 91362	818-234-4214	Full Service	Steven Alseth
21555 Oxnard Street; Woodland Hills, CA 91367	818-234-2344	Sacramento	judy.vaccaro@wellpoint.com
933 0415 - Blue Cross of California Partnership Plan (QIF)	Brian Fields	933 0415	Katie Coyne
	VP, Deputy General Counsel	12/30/2004	Grace Jimenez-Hennessy
1 Wellpoint Way; Thousand Oaks, CA 91362	805-557-6508	QIF	Steven Alseth
1 Wellpoint Way; Thousand Oaks, CA 91362	805-557-6518		brian.fields@wellpoint.com
933 0308 - California Benefits Dental Plan	Valerie A. Clark	933 0308	Crystal Chen
	President & CEO	07/30/1992	Amy Fong
3611 S. Harbor Blvd., Ste 150; Santa Ana, CA 92704	714 540-4255	Dental	Evan Lo
3611 S. Harbor Blvd., Ste 150; Santa Ana, CA 92704	714 540-4754	Sacramento	valerie.clark@sunlife.com

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Plan Name / Dba1 / Street Address / Mailing Address	Contact Person / Title / Phone Number / FAX Number	File No. \ Plan ID / Date Licensed / Type / Location of Files	License Counsel / Medical Survey Analyst / Examiner / Contact E-mail Address
933 0286 - California Dental Network, Inc.	Stephen R. Casey	933 0286	Crystal Chen
F: Alternative Dental Care of Calif., Inc.	President and CEO	05/12/1988	James Hollister
1971 E. 4th Street, Suite 184; Santa Ana, CA 92705	714 479-0777	Dental	Barbara Yaklin
1971 E. 4th Street, Suite 184; Santa Ana, CA 92705	714 479-0779	Sacramento	scasey@caldental.net
933 0043 - California Physicians' Service	Lyle Swallow	933 0043	Nancy Pheng
dba: Blue Shield of California	Assoc. General Counsel	07/27/1978	Tammy Putnam
50 Beale Street, 22nd Floor; San Francisco, CA 94105	415 229-5821	Full Service	Lorilee Ambrosini
P.O. Box 7168; San Francisco, CA 94120-7168	415 229-6208	Sacramento	lyle.swallow@blueshieldca.com
933 0326 - Care 1st Health Plan	Anna Tran	933 0326	Lily Donn
	CEO	11/01/1995	Tammy Putnam
601 N. Potrero Grande Drive; Monterey Park, CA 91755	323-889-6638	Full Service	Jefferey Roskelley
601 N. Potrero Grande Drive; Monterey Park, CA 91755		Sacramento	atran@care1st.com
933 0443 - Care 1st Health Plan Partner (QIF)	Anna Tran	933 0443	Lily Donn
	CEO	12/09/2005	
601 N. Potrero Grande Drive; Monterey Park, CA 91755	323-889-6638	QIF	Jefferey Roskelley
601 N. Potrero Grande Drive; Monterey Park, CA 91755			atran@care1st.com

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Department of Managed Health Care
List of All Licensed Plans

Alphabetical Report

Plan Name / Dba1 / Street Address / Mailing Address	Contact Person / Title / Phone Number / FAX Number	File No. \ Plan ID / Date Licensed / Type / Location of Files	License Counsel / Medical Survey Analyst / Examiner / Contact E-mail Address
933 0408 - CareMore Health Plan	Cindy Lynch	933 0408	Kathleen Mc Knight
F:California Health Plan	Director of Regulatory Affairs	11/01/2002	Patrick Bober
12900 Park Plaza Drive, Suite 150; Cerritos, CA 90703	562-741-4552	Full Service	Evan Lo
12900 Park Plaza Drive, Suite 150; Cerritos, CA 90703	562-622-2925	Sacramento	cindy.lynch@caremore.org
933 0404 - Central Health Plan of California, Inc.	Sam Kam	933 0404	Katie Coyne
	President	10/27/2004	Patrick Bober
1051 Parkview Drive, Suite 120; Covina, CA 91724	626-388-2300	Full Service	Maryam Tahriri
1051 Parkview Drive, Suite 120; Covina, CA 91724	626-388-2320	Sacramento	chpinfo@centralhealthplan.com
933 0431 - CHG Foundation (QIF)	Joseph Garcia	933 0431	Kathleen Mc Knight
Community Health Group Partnership Plan	Chief of Operations	06/23/2005	
740 Bay Boulevard; Chula Vista, CA 91910	619-498-6557	QIF	Barbara Yaklin
740 Bay Boulevard; Chula Vista, CA 91910	619-422-5930		JGarcia@chgsd.com
933 0278 - Chinese Community Health Plan	Richard Loos	933 0278	Lily Donn
	CEO	07/31/1987	James Hollister
445 Grant Avenue, Suite 700; San Francisco, CA 94108	415-955-8800	Full Service	Hung Truong
445 Grant Avenue, Suite 700; San Francisco, CA 94108	415-955-8818	Sacramento	rloos@cchphmo.com

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Plan Name Dba1 Street Address Mailing Address	Contact Person Title Phone Number FAX Number	File No. \ Plan ID Date Licensed Type Location of Files	License Counsel Medical Survey Analyst Examiner Contact E-mail Address
933 0298 - Cigna Behavioral Health of California, Inc.	Nicholas Osterman	933 0298	Elaine Paniewski
F:MCC Managed Behavioral Care, MCC Behavioral Care	President/Director	08/01/1990	Susan Burger
450 North Brand Blvd, Suite 500; Glendale, CA 91203	818-551-2755	Psychological	Vasiliy Lopuga
450 North Brand Blvd, Suite 500; Glendale, CA 91203	818 547-1893	Sacramento	susan.urbanski@cignabehavioralcom
933 0258 - Cigna Dental Health of California, Inc.	Michelle Nguyen	933 0258	Crystal Chen
None	President/Chief Executive Officer	03/11/1986	Susan Burger
400 North Brand Blvd., Suite 400; Glendale, CA 91203	818 500-6343	Dental	Vasiliy Lopuga
400 North Brand Blvd., Suite 400; Glendale, CA 91203	818 546-5102	Sacramento	michelle.nguyen@cigna.com
933 0152 - Cigna HealthCare of California, Inc.	William S. Jameson	933 0152	Marie Eppler
F: Ross Loos H.P. of Ca, Inc./ Equicor	Chief Counsel	03/23/1979	Susan Burger
400 North Brand Blvd., #400; Glendale, CA 91203	818 500-6276	Full Service	Vasiliy Lopuga
P. O. Box 2125; Glendale, CA 91209	818 500-6365	Sacramento	william.jameson@cigna.com
933 0170 - Community Dental Services	Joseph Sivori	933 0170	Crystal Chen
dba: Smilecare	Acting President	05/06/1982	Wendy Jang
2 McAurthur Place, Suite 700; Santa Ana, CA 92707	714-708-5376	Dental	Sang Le
2 McAurthur Place, Suite 700; Santa Ana, CA 92707	714 708-5399	Sacramento	jsivori@smilecare.com

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Plan Name Dba1 Street Address Mailing Address	Contact Person Title Phone Number FAX Number	File No. \ Plan ID Date Licensed Type Location of Files	License Counsel Medical Survey Analyst Examiner Contact E-mail Address
933 0200 - Community Health Group	Francisca Chavez	933 0200	Kathleen Mc Knight
None	Regulatory Affairs Manager	08/30/1985	Shelly Williams
740 Bay Boulevard; Chula Vista, CA 91910	619-498-6589	Full Service	Barbara Yaklin
740 Bay Boulevard; Chula Vista, CA 91910	619-476-3834	Sacramento	fchave@chgsd.com
933 0402 - CONCERN: Employee Assistance Program	Cecile Currier	933 0402	Elaine Paniewski
	CEO	03/05/2001	Susan Burger
1503 Grant Road, Suite 120; Mountain View, CA 94040	650 988-7401	Psychological	Jamey Matalka
1503 Grant Road, Suite 120; Mountain View, CA 94040	650 966-9291	Sacramento	cecile_currier@concern-eap.com
933 0215 - ConsumerHealth, Inc.	Dennis Fratt	933 0215	Crystal Chen
Bright Now! Dental, Newport Dental Plan	Chief Operating Officer	06/18/1985	Wendy Jang
201 E. Sandpointe, Floor 8; Santa Ana, CA 92707	714 668-1300	Dental	Jamey Matalka
201 E. Sandpointe, Floor 8; Santa Ana, CA 92707	714 428-1330	Sacramento	dfratt@brightnow.com
933 0054 - Contra Costa County Medical Services	Patricia Tanquary	933 0054	Kathleen Mc Knight
dba: Contra Costa Health Plan	CEO	04/06/1978	Anne Potter
595 Center Avenue, Suite 100; Martinez, CA 94553	925 313-6004	Full Service	Jefferey Roskelley
595 Center Avenue, Suite 100; Martinez, CA 94553	925 313-6002	Sacramento	ptanquary@hsd.co.contra-costa.ca.us

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933 0424 - Contra Costa County Medical Services (QIF)	Patricia Tanquary	933 0424	Kathleen Mc Knight
Contra Costa Health Plan-Community Plan	CEO	05/19/2005	
595 Center Avenue, Suite 100; Martinez, CA 94553	925-313-6004	QIF	Jefferey Roskelley
595 Center Avenue, Suite 100; Martinez, CA 94553			ptanquary@hsd.co.contra-costa.ca.us
933 0248 - County of Los Angeles-Dept of Health Srvcs.	Teri Lauenstein	933 0248	Kathleen Mc Knight
dba: Community Health Plan	Director	12/30/1985	Marie Broadnax
1000 S. Fremont Ave., Building A-9, East 2nd Floor; Alhambra, CA 91	626 299-5300	Full Service	Maryam Tahriri
1000 S. Fremont Ave., Bldg A-9, E. 2nd Floor,U 4; Alhambra, CA 91	626 458-6761	Sacramento	tlauenstein@ladhs.org
933 0344 - County of Ventura	Larry C. Keller	933 0344	Kathleen Mc Knight
dba: Ventura County Health Care Plan	Insurance Service Administrator	06/06/1996	Randi Wise
2323 Knoll Drive, #417; Ventura, CA 93003	805 677-5151	Full Service	Jamey Matalka
2323 Knoll Drive, #417; Ventura, CA 93003	805 677-5323	Sacramento	VCHCP.Admin@ventura.org
933 0244 - Dedicated Dental Systems, Inc.	Robert Hill	933 0244	Crystal Chen
F: K & R Dental Plan (dba) DDS, Inc., DDSI	Chief Executive Officer	12/23/1986	Wendy Jang
3990 Ming Avenue; Bakersfield, CA 93309	310 765 2470	Dental	Barbara Yaklin
3990 Ming Avenue; Bakersfield, CA 93309		Sacramento	hillr@interdent.com

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933 0092 - Delta Dental of California	Robert G. Becker	933 0092	Crystal Chen
F: California Dental Services	General Counsel	03/22/1978	Wendy Jang
100 First Street; San Francisco, CA 94105	415 972-8300	Dental/Vision	Nelly Wei
100 First Street; San Francisco, CA 94105	415 972-8483	Sacramento	Bbecker@delta.org
933 0255 - Dental Benefit Providers of California, Inc.	Kirk Andrews	933 0255	Crystal Chen
dba: Dental Choice of CA Inc.	President	06/30/1986	Wendy Jang
425 Market St., 12th Fl, M/S CA035-1200; San Francisco, CA 94105714-513-6425		Dental	Lorilee Ambrosini
425 Market St., 12th Fl, M/S CA035-1200; San Francisco, CA 94105714-513-6486		Sacramento	kirk.andrews@phs.com
933 0059 - Dental Health Services	Michael Fenton	933 0059	Crystal Chen
	Chief Financial Officer	03/29/1978	Wendy Jang
3833 Atlantic Avenue; Long Beach, CA 90807-3505	562-276-1160	Dental	Vasiliy Lopuga
3833 Atlantic Avenue; Long Beach, CA 90807-3505	562 424-0150	Sacramento	mfenton@dentalhealthservices.com
933 0457 - EASY CHOICE HEALTH PLAN, Inc.	Eric Spencer	933 0457	Lily Donn
EZ CHOICE HEALTH PLAN, Inc.	President	06/11/2007	
20411 SW Birch Street, Suite 200; Newport Beach, CA 92660	949-999-3748	Full Service	Jessica Tran
20411 SW Birch Street, Suite 200; Newport Beach, CA 92660			espencer@healthsmartmso.com

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933 0458 - Envision Insurance Company	Eugene Samuels	933 0458	Kathleen Mc Knight
	Secretary/General Counsel	12/31/2007	
5140 Robert J. Mathews Parkway, Suite 100; El Dorado Hills, CA 95	480-393-0684	Pharmacy	Bill Chang
4601 W. Flint Street; Chandler, AZ 85226			esamuels@envisionrx.com
933 0264 - EYEXAM of California, Inc.	Lisa Isenhart	933 0264	Marie Eppler
F: EYEMED, Inc.	Controller	11/17/1986	Tammy Putnam
29 The Shops at Mission Viejo; Mission Viejo, CA 92691-6513	949 364-2256	Vision	Jessica Tran
29 The Shops at Mission Viejo; Mission Viejo, CA 92691-6513	949 364-0265	Sacramento	lisenhar@luxotticaretail.com
933 0435 - First Dental Health (New Dental Choice)	Michael Grossman	933 0435	Crystal Chen
	President/CEO	10/10/2006	Wendy Jang
7220 Trade Street #350; San Diego, CA 92121	858-444-2615	Dental	Nelly Wei
7220 Trade Street #350; San Diego, CA 92121			mgrossman@firstdentalhealth.com
933 0342 - FirstSight Vision Services, Inc.	Robert K. Patton	933 0342	Marie Eppler
F: NVAL Visioncare Systems of California, Inc.	President and CEO	12/27/1996	Susan Burger
1202 North Monte Vista Avenue, Suite 17; Upland, CA 91786	909 920-5008	Vision	Jessica Tran
1202 North Monte Vista Avenue, Suite 17; Upland, CA 91786	909 932-0062	Sacramento	robert.patton@firstsightvision.ne

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933 0320 - For Eyes Vision Plan, Inc.	Frederick Hjerpe	933 0320	Marie Eppler
	President	07/18/1996	Susan Burger
2112 Shattuck Avenue; Berkeley, CA 94704	510 843-3200	Vision	Jessica Tran
2112 Shattuck Avenue; Berkeley, CA 94704	510 843-2597	Sacramento	fhjerpe@foreyes.com
933 0445 - GEMCare Health Plan, Inc.	Michael Myers	933 0445	Lily Donn
	Chief Executive Officer	02/28/2006	Patrick Bober
4550 California Avenue, Suite 100; Bakersfield, CA 93309	661-716-8820	Full Service	Evan Lo
4550 California Avenue, Suite 100; Bakersfield, CA 93309			mmyers@gemcarehealthplan.cor
933 0080 - Golden West Health Plan, Inc.	Brian Fields	933 0080	Crystal Chen
F: Golden West Vison-Dental Plan; Ventura Dental	VP, Deputy General Counsel	11/09/1978	
5171 Verdugo Way; Camarillo, CA 93010	805-557-6508	Dental/Vision	Jamey Matalka
1 WellPoint Way; Thousand Oaks, CA 91362	805-557-6518	Sacramento	brian.fields@wellpoint.com
933 0325 - Great-West Healthcare of California, Inc.	Mr. Anand Raghavan	933 0325	Marie Eppler
F: One Healh Plan of California, Inc.	Treasurer,Secretary,Financial Director	03/22/1996	Christopher Ermolik
655 N. Central Ave., Ste 1900; Glendale, CA 91203	818 539 9305	Full Service	Evan Lo
655 N. Central Ave., Ste 1900; Glendale, CA 91203	818 545 9238	Sacramento	anand.raghavan@gwl.com

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Plan Name Dba1 Street Address Mailing Address	Contact Person Title Phone Number FAX Number	File No. \ Plan ID Date Licensed Type Location of Files	License Counsel Medical Survey Analyst Examiner Contact E-mail Address
933 0319 - Health and Human Resource Center	Peggy Wagner	933 0319	Elaine Paniewski
Horizon Health EAP - Behavioral Services	President	11/30/1993	
9370 Sky Park Court, Suite 140; San Diego, CA 92123	858 571-1698	Psychological	Vasiliy Lopuga
9370 Sky Park Court, Suite 140; San Diego, CA 92123	858 712-1698	Sacramento	peggy.wagner@horizonhealth.com
933 0426 - Health Net Community Solutions, Inc. (QIF)	Franklin Tom	933 0426	Linda Azzolina
	Vice President, Legal	06/13/2005	
21281 Burbank Boulevard; Woodland Hills, CA 91367	818-676-8965	QIF	Barbara Yaklin
P.O. Box 9103; Van Nuys, CA 91409-9103	818-676-8097	Sacramento	franklin.tom@healthnet.com
933 0300 - Health Net of California, Inc.	Franklin Tom	933 0300	Linda Azzolina
F: Qualmed Plans For Health/Bridgeway/Health Net	Vice Pres. Legal Services	03/07/1991	Van Vu
21281 Burbank Blvd.; Woodland Hills, CA 91367	818 676-8965	Full Service	Barbara Yaklin
21650 Oxnard St, Suite 1560; Woodland Hills, CA 91367	818 676-8097	Sacramento	franklin.tom@health.net
933 0442 - Health Plan of San Joaquin Joint Powers Authority	John Hackworth	933 0442	Kathleen Mc Knight
	CEO	12/01/2005	
7751 S. Manthey Road; French Camp, CA 95231	209-942-6300	QIF	Jefferey Roskelley
7751 S. Manthey Road; French Camp, CA 95231	209-942-6305		jhackworth@hpsj.com

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933 0357 - Heritage Provider Network, Inc. [1]	Jaya Kurian	933 0357	Nancy Pheng
	Sr. Vice President, CFO	02/07/1997	Van Vu
8510 Balboa Blvd., Suite 285; Northridge, CA 91325	818 654-3461	Full Service	Evan Lo
8510 Balboa Blvd., Suite 285; Northridge, CA 91325	818 654-3460	Sacramento	jkurian@hdmg.net
933 0231 - Holman Professional Counseling Centers	Marcus Sola	933 0231	Elaine Paniewski
None	Sr. Vice President	06/28/1985	Randi Wise
9451 Corbin Avenue, Suite 100; Northridge, CA 91324	818 704-1444	Psychological	Vasiliy Lopuga
9451 Corbin Avenue, Suite 100; Northridge, CA 91324	818 704-9339	Sacramento	marcuss@holmangroup.com
933 0414 - Honored Citizens Choice Health Plan, Inc.	Parvis Kahen	933 0414	Lily Donn
Citizens Choice Healthplan	President/COO	05/25/2004	Patrick Bober
17315 Studebaker Road, Suite 200; Cerritos, CA 90703	323-728-7232	Full Service	Barbara Yaklin
17315 Studebaker Road, Suite 200; Cerritos, CA 907033	323-728-8494	Sacramento	parvis32@aol.com
933 0292 - Human Affairs International of California	Pamela Masters	933 0292	Elaine Paniewski
dba: HAI, HAI-CA	President	06/30/1989	Randi Wise
300 Continental Blvd., Suite 240; El Segundo, CA 90245	310 726-7121	Psychological	Barbara Yaklin
300 Continental Blvd., Suite 240; El Segundo, CA 90245	310 726-7090	Sacramento	pjmasters@magellanhealth.com

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933 0428 - IEHP Health Access (QIF)	Greg Kono	933 0428	Lily Donn
	Senior Compliance Manager	06/23/2005	
303 East Vanderbilt Way; San Bernardino, CA 92408	909-890-2912	QIF	Daniele Lopes
P.O. Box 19026; San Bernardino, CA 92423	909-890-2973		kono-g@iehp.org
933 0346 - Inland Empire Health Plan	Greg Kono	933 0346	Lily Donn
dba: IEHP	Senior Compliance Manager	07/22/1996	Shelly Williams
303 East Vanderbilt Way, Ste 400; San Bernardino, CA 92408	909 890-2912	Full Service	Daniele Lopes
P.O. Box 19026; San Bernardino, CA 92423-9026	909 890-2702	Sacramento	kono-g@iehp.org
933 0151 - Inter Valley Health Plan	Ronald Bolding	933 0151	Lily Donn
F: Pomona Valley Health Plan, Inc.	Chief Executive Officer	05/25/1979	Patrick Bober
300 South Park Avenue, Suite 300; Pomona, CA 91766	909 623-6333	Full Service	Hung Truong
300 S. Park Avenue; Pomona, CA 91769	909 397-9039	Sacramento	
933 0197 - Jaimini Health Inc.	Michael Polis	933 0197	Crystal Chen
Primecare Dental	Outside Counsel	07/15/1983	Marie Broadnax
9500 Haven Avenue, Suite 125; Rancho Cucamonga, CA 91730	916 441-2430	Dental	Vasiliy Lopuga
9500 Haven Avenue, Suite 125; Rancho Cucamonga, CA 91730	916 442-6664	Sacramento	mpolis@wilkefleury.com

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933 0055 - Kaiser Foundation Health Plan, Inc.	Maria Borje-Bonkowski	933 0055	Elizabeth Spring
dba: Kaiser Foundation/Permanente Med. Care Prog	Director, HP Licensing/Submissions	11/04/1977	Christopher Ermolik
2101 Webster Street, 8th Floor; Oakland, CA 94612	510 627-2677	Full Service	Sang Le
2101 Webster Street, 8th Floor; Oakland, CA 94612	510 627-2592	Sacramento	Maria.Borje-Bonkowski@kp.org
933 0335 - Kern Health Systems	Carol L. Sorrell	933 0335	Kathleen Mc Knight
	CEO	05/06/1996	Anne Potter
9700 Stockdale Highway; Bakersfield, CA 93311	661-664-5010	Full Service	Anna Belmont
9700 Stockdale Highway; Bakersfield, CA 93311	661-664-5178	Sacramento	carols@khs-net.com
933 0425 - Kern Health Systems Group Health Plan	Carol Sorrell	933 0425	Kathleen Mc Knight
	Chief Executive Officer	06/24/2005	
9700 Stockdale Highway; Bakersfield, CA 93311	661-664-5010	QIF	Anna Belmont
9700 Stockdale Highway; Bakersfield, CA 93311	661-664-5178		carols@khs-net.com
933 0438 - KP Cal, LLC (QIF)	Maria Borje-Bonkowski	933 0438	Elizabeth Spring
	Director, Health Plan Licensing	02/14/2006	
One Kaiser Plaza, 19th floor; Oakland, CA 94612	510-627-2677	QIF	Sang Le
2101 Webster Street, 8th Floor; Oakland, CA 94612	510-627-2592		Maria.Borje-Bonkowski@kp.org

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933 0452 - Lakeside Comprehensive HealthCare, Inc.	Kermit Newman	933 0452	Lily Donn
	CFO	05/21/2007	
777-A Flower Street; Glendale, CA 91201	818-637-2000 x1110	Full Service	Daniele Lopes
777-A Flower Street; Glendale, CA 91201			kermit_newman@lakesidemed.com
933 0361 - Landmark Healthplan of California, Inc.	George Vieth	933 0361	Marie Eppler
	President/CEO	09/09/1997	Susan Burger
1750 Howe Avenue, Suite 300; Sacramento, CA 95825-3369	916 569-3301	Chiropractic	Hung Truong
1750 Howe Avenue, Suite 300; Sacramento, CA 95825-3369	916 646-6358	Sacramento	gvieth@lmhealthcare.com
933 0052 - Liberty Dental Plan of California, Inc.	Amir Neshat	933 0052	Crystal Chen
dba: Personal Dental Services	President, CEO	08/03/1978	Wendy Jang
3200 El Camino Real, Suite 290; Irvine, CA 92602	949 223 0007	Dental	Daniele Lopes
P.O. Box 26110; Santa Ana, CA 92799	949 223 0011	Sacramento	drn@libertydentalplan.com
933 0355 - Local Initiative Health Authority For L.A. County	Augustavia J. Haydel	933 0355	Kathleen Mc Knight
dba: L.A. Care Health Plan	Chief Legal Officer	04/01/1997	Anne Potter
555 W. Fifth St., 29th Floor; Los Angeles, CA 90013-3036	213 694-1250	Full Service	Maryam Tahriri
555 W. Fifth St., 29th Floor; Los Angeles, CA 90013-3036	213 438-5724	Sacramento	Ahaydel@lacare.org

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933 0102 - Magellan Health Services of California-EmployerSvc	Pamela Masters	933 0102	Elaine Paniewski
F: Vista Behavioral Health Plans	President	08/02/1978	Randi Wise
300 Continental Blvd., Suite 240; El Segundo, CA 90245	310 726-7121	Psychological	Barbara Yaklin
300 Continental Blvd., Suite 240; El Segundo, CA 90245	310 726-7090	Sacramento	
933 0302 - Managed Dental Care	Candee Bolyog	933 0302	Crystal Chen
F: Managed Dental Care of California/MDC	President	12/24/1991	Amy Fong
6200 Canoga Ave., Suite 100; Woodland Hills, CA 91367	818 596-5825	Dental	Jessica Tran
6200 Canoga Ave., Suite 100; Woodland Hills, CA 91367	818 598-8653	Sacramento	candee_bolyog@glic.com
933 0196 - Managed Health Network	Marshall Bentley	933 0196	Elaine Paniewski
F: California Wellness Plan	Interim V.P., Legal and Regulatory Affairs	03/10/1983	Marie Broadnax
1600 Los Gamos Drive, Suite 300; San Rafael, CA 94903	510-287-4586	Psychological	Barbara Yaklin
P.O. Box 9088; San Rafael, CA 94903		Sacramento	marshall.bentley@healthnet.com
933 0446 - March Vision Care, Inc.	Glenville March	933 0446	Marie Eppler
	President/CEO	11/13/2006	Van Vu
6701 Center Dr. West, Suite 790; Los Angeles, CA 90045	310-216-2300	Vision	Jefferey Roskelley
6701 Center Drive West, Suite 790; Los Angeles, CA 90045			gmarch@marchvisioncare.com

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933 0417 - Max Vision Care, Inc., A Prof. Optometric Corp	Mark Galvan	933 0417	Marie Eppler
	President	03/01/2007	
6711 Comstock Avenue; Whittier, CA 90601	562-698-0027	Vision	Barbara Yaklin
6711 Comstock Avenue; Whittier, CA 90601			markgalvan@maxvisioncare.com
933 0462 - MD Care, Inc.	Lan Pham	933 0462	Kathleen Mc Knight
	Chief Operating Officer	07/06/2007	
10941 Bloomfield Street, Suite F; Los Alamitos, CA 90720	562-344-3400	Full Service	Anna Belmont
10941 Bloomfield Street, Suite F; Los Alamitos, CA 90720	562-344-3420		lpham@mdcareinc.com
933 0390 - Medcore HP	Kirit B. Patel	933 0390	Lily Donn
dba: Medcore	Chairman of the Board	06/26/2002	Patrick Bober
509 W. Weber Avenue, Suite 200; Stockton, CA 95203	209 320-2600	Full Service	Allan Campbell
509 W. Weber Avenue, Suite 200; Stockton, CA 95203	209 320-2641	Sacramento	
933 0359 - Medical Eye Services, Inc.	Ms. Aspasia Shappet	933 0359	Marie Eppler
	President/CEO, CFO	12/22/1997	Marie Broadnax
345 Baker Street East; Costa Mesa, CA 92626	714 619-4660	Vision	Evan Lo
P.O. Box 25209; Santa Ana, CA 92799-5209	714 619-4662	Sacramento	rguerrero@mesvision.com

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933 0322 - Molina Healthcare of California	Stephen O'Dell	933 0322	Kathleen Mc Knight
dba: American Family Care, Molina Medical Center	President	03/14/1994	Shelly Williams
200 Oceangate, Ste. 100; Long Beach, CA 90802	562-491-7019	Full Service	Jamey Matalka
200 Oceangate, Ste. 100; Long Beach, CA 90802	562-499-6170	Sacramento	steve.odell@molinahealthcare.com
933 0427 - Molina Healthcare of California Partner Plan, Inc.	Stephen O'Dell	933 0427	Kathleen Mc Knight
	President	06/16/2005	Shelly Williams
200 Oceangate, Ste. 100; Long Beach, CA 90802	562-491-7019	QIF	Jamey Matalka
200 Oceangate, Ste. 100; Long Beach, CA 90802	562-499-6170		steve.odell@molinahealthcare.com
933 0453 - Monarch Health Plan	Karen Goldstein	933 0453	Lily Donn
	General Manager	04/18/2007	
7 Technology Drive; Irvine, CA 92618	949-923-3246	Full Service	Jamey Matalka
7 Technology Drive; Irvine, CA 92618	949-923-3350		kgoldstein@mhealth.com
933 0385 - On Lok Senior Health Services	Amy Shin	933 0385	Lily Donn
	Health Plan Director	01/20/1999	Anne Potter
1333 Bush Street; San Francisco, CA 94109	415 292-8713	Full Service	Anna Belmont
1333 Bush Street; San Francisco, CA 94109	415 292-8745	Sacramento	ashin@onlok.org

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933 0394 - Orange County Health Authority	Margaret Tatar	933 0394	Lily Donn
Caloptima	Director,Compliance and Reg. Affairs	06/28/2000	Shelly Williams
1120 West La Veta Avenue; Orange, CA 92868	714 246-8796	Full Service	Nelly Wei
1120 West La Veta Avenue, Suite 200; Orange, CA 92868	714-246-8562	Sacramento	mtatar@caloptima.org
933 0211 - Pacific Union Dental, Inc.	Kirk Andrews	933 0211	Crystal Chen
F: California Pacific Dental, Inc.	President	12/26/1984	Wendy Jang
2300 Clayton Road, Suite 1000; Concord, CA 94520	714-513-6425	Dental	Lorilee Ambrosini
2300 Clayton Road, Suite 1000; Concord, CA 94520	714-513-6486	Sacramento	kirk.andrews@phs.com
933 0301 - PacifiCare Behavioral Health of California Inc.	Nancy Monk	933 0301	Elaine Paniewski
F: Lifelink, Inc., Psychology Systems	Vice Pres., Govt/Regulatory Affairs	01/13/1992	Anne Potter
3120 Lake Center Drive; Santa Ana, CA 92704-6917	714 226-3582	Psychological	Lorilee Ambrosini
5995 Plaza Drive, CA 112-0267; Cypress, CA 90630	714 226-3025	Sacramento	nancy.monk@phs.com
933 0100 - PacifiCare Dental	Nancy Monk	933 0100	Crystal Chen
dba: CDHP	Vice President, Relations	02/28/1979	Anne Potter
3110 Lake Center Drive; Santa Ana, CA 92704	714 226-3582	Dental	Lorilee Ambrosini
5995 Plaza Drive, CA 112-0267; Cypress, CA 90630	714 226-3025	Sacramento	nancy.monk@phs.com

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933 0126 - PacifiCare of California	Nancy J. Monk	933 0126	Linda Azzolina
dba: Secure Horizons, Health Plan of America (HPA)	Vice President, Gov't Relations	05/15/1978	Marie Broadnax
5995 Plaza Drive MS CY20-267; Cypress, CA 90630	714 226-3582	Full Service	Lorilee Ambrosini
5995 Plaza Drive MS CA112-0267; Cypress, CA 90630	714 226-3025	Sacramento	nancy.monk@phs.com
933 0416 - Partnership HealthPlan of California	Jack Horn	933 0416	Lily Donn
F: Solano-Napa-Yolo Commission on Medical Care	CEO	11/04/2005	Anne Potter
360 Campus Ln., Ste 100; Fairfield, CA 94534	707-863-4240	Full Service	Allan Campbell
360 Campus Ln., Ste 100; Fairfield, CA 94534			jhorn@partnershiphp.org
933 0263 - Pearle Visioncare, Inc.	Debbie Hyde-Duby	933 0263	Marie Eppler
	President	11/04/1986	Randi Wise
6727 Flanders Dr., Suite 104; San Diego, CA 92121	800-843-6706	Vision	Jessica Tran
6727 Flanders Dr., Suite 104; San Diego, CA 92121	858 625-9181	Sacramento	dhduby@luxotticaretail.com
933 0367 - PRIMECARE Medical Network, Inc. [1]	Elizabeth S. Haughton	933 0367	Nancy Pheng
	Director of Legal Affairs	10/16/1998	Susan Burger
3281 East Guasti Road, 7th Floor; Ontario, CA 91761-7643	909 605-8000	Full Service	Daniele Lopes
3281 East Guasti Road, 7th Floor; Ontario, CA 91761-7643	909 605-8033	Sacramento	ehaughton@nammcal.com

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933 0409 - Robert T. Dorris & Associates	Barbara Weir	933 0409	Elaine Paniewski
	CEO	04/27/2004	James Hollister
31416 Agoura Road, Suite 180; Westlake Village, CA 91361	(818) 707-0544	Psychological	Anna Belmont
31416 Agoura Road, Suite 180; Westlake Village, CA 91361		Sacramento	barbaraweir@dorris.com
933 0034 - SafeGuard Health Plans, Inc.	Ronald I. Brendzel	933 0034	Marie Eppler
None	Sr. Vice President	12/17/1981	Amy Fong
95 Enterprise, Suite 100; Aliso Viejo, CA 92656-2601	949 425-4110	Dental/Vision	Anna Belmont
95 Enterprise, Suite 100; Aliso Viejo, CA 92656-2601	949 425-4586	Sacramento	rbrendzel@safeguard.net
933 0423 - San Francisco Community Health Authority	Richard Rubinstein	933 0423	Lily Donn
	Senior Counsel	05/23/2005	
201 Third Street, 7th Floor; San Francisco, CA 94103	415-615-4214	Full Service	Nelly Wei
201 Third Street, 7th Floor; San Francisco, CA 94103			rrubinstein@sfhp.org
933 0349 - San Francisco Health Authority (QIF)	Richard Rubinstein	933 0349	Lily Donn
dba: San Francisco Health Plan	Senior Counsel	08/13/1996	Anne Potter
201 Third Street, 7th Floor; San Francisco, CA 94103	415-615-4214	QIF	Nelly Wei
201 Third Street, 7th Floor; San Francisco, CA 94103		Sacramento	rrubinstein@sfhp.org

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933 0338 - San Joaquin County Health Commission	John Hackworth	933 0338	Kathleen Mc Knight
dba: The Health Plan of San Joaquin	CEO	01/30/1996	Anne Potter
7751 S. Manthey Road; French Camp, CA 95231	209 942-6300	Full Service	Jennifer Lum
7751 S. Manthey Road; French Camp, CA 95231	209 942-6305	Sacramento	jhackworth@hpsj.com
933 0439 - San Mateo Community Health Plan (QIF)	Ellen Dunn-Malhotra	933 0439	Lily Donn
	Director of Planning & Evaluation	02/23/2006	Anne Potter
701 Gateway Blvd., Suite 400; So. San Francisco, CA 94080	650-616-0050	QIF	Jefferey Roskelley
701 Gateway Blvd., Suite 400; So. San Francisco, CA 94080	650-616-0060	Sacramento	edunn-malhotra@hpsm.org
933 0358 - San Mateo Health Commission	Ellen Dunn-Malhotra	933 0358	Lily Donn
dba: Health Plan of San Mateo	Director of Planning & Evaluation	07/31/1998	Anne Potter
701 Gateway Blvd., Suite 400; So. San Francisco, CA 94080	650 616-0050	Full Service	Jefferey Roskelley
701 Gateway Blvd., Suite 400; So. San Francisco, CA 94080	650 616-0060	Sacramento	edunn-malhotra@hpsm.org
933 0459 - San Miguel Health Plan	Gerry Long	933 0459	Lily Donn
	Chief Operations Officer	07/13/2007	
7646 Densmore; Van Nuys, CA 91406	562-435-3400	Full Service	Jefferey Roskelley
100 W. Broadway, Suite 5000; Long Beach, CA 90802	562-435-9200		glong@sanmiguelhealthplan.com

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933 0400 - Santa Barbara San Luis Obispo Regional Health Auth	Robert Freeman	933 0400	Kathleen Mc Knight
CenCal Health	Deputy Executive Director	06/22/2000	Anne Potter
110 Castilian Drive; Goleta, CA 93117-3028	800 421-2560	Full Service	Jennifer Lum
110 Castilian Drive; Goleta, CA 93117-3028	805 685-8292	Sacramento	bobf@sbrha.org
933 0444 - Santa Clara Community Health Authority (QIF)	Leona Butler	933 0444	Lily Donn
	Chief Executive Officer	05/11/2006	
210 East Hacienda Avenue; Campbell, CA 95008	408-874-1702	QIF	Daniele Lopes
210 East Hacienda Avenue; Campbell, CA 95008	408-376-2191		lbutler@scfhp.com
933 0236 - Santa Clara County	Greg Price	933 0236	Kathleen Mc Knight
dba: Valley Health Plan; Santa Clara Valley Med Ct	CEO	09/13/1985	Randi Wise
2325 Enborg Lane, Ste 290H; San Jose, CA 95128	408 885-5704	Full Service	Daniele Lopes
2325 Enborg Lane, Ste 290H; San Jose, CA 95128	408 885-5921	Sacramento	greg.price@hhs.co.scl.ca.us
933 0351 - Santa Clara County Health Authority	Leona Butler	933 0351	Lily Donn
dba: Santa Clara Family Health Plan	Chief Executive Officer	12/20/1996	Anne Potter
210 East Hacienda Avenue; Campbell, CA 95008	408 874-1702	Full Service	Daniele Lopes
210 East Hacienda Avenue; Campbell, CA 95008	408 376-2191	Sacramento	lbutler@scfhp.com

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933 0401 - Santa Cruz - Monterey Managed Medical Care Comm.	Danita Carlson	933 0401	Lily Donn
dba: Central Coast Alliance for Health	Government Relations Consultant	06/20/2000	Anne Potter
1600 Green Hills Road; Scotts Valley, CA 95066	831 430-5500	Full Service	Nelly Wei
1600 Green Hills Road; Scotts Valley, CA 95066	831 430-5852	Sacramento	dcarlson@ccah-alliance.org
933 0212 - Scan Health Plan	Rebecca M. Learner	933 0212	Lily Donn
	Sr. Vice Pres & Compliance Officer	11/30/1984	Patrick Bober
3800 Kilroy Airport Way, Suite 100; Long Beach, CA 90801-5616	562 989-4454	Full Service	Barbara Yaklin
3800 Kilroy Airport Way, Suite 100; Long Beach, CA 90801-5616	562 989-5120	Sacramento	blearner@scanhealthplan.com
933 0377 - Scripps Clinic Health Plan Services, Inc.	Kirsten L. Patalano	933 0377	Nancy Pheng
	Compliance Manager	04/07/1999	Amy Fong
10170 Sorrento Valley Road, SV4; San Diego, CA 92121	858 784-5961	Full Service	Anna Belmont
10170 Sorrento Valley Road, SV4; San Diego, CA 92121	858 784-5837	Sacramento	Patalano.Kirsten@scrippshealth.org
933 0310 - Sharp Health Plan	Melissa Cook	933 0310	Marie Eppler
	President/CEO	09/17/1992	Susan Burger
4305 University Avenue, Suite 200; San Diego, CA 92105	619 228-2440	Full Service	Vasiliy Lopuga
4305 University Avenue, Suite 200; San Diego, CA 92105	619 228-2444	Sacramento	melissa.cook@sharp.com

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933 0464 - SilverScript Insurance Company	Sarah Doyle	933 0464	Kathleen Mc Knight
	Senior Paralegal	04/04/2008	
211 Commerce Street, Suite 800; Nashville, TN 37201	847-559-4765	Pharmacy	Jessica Tran
2211 Sanders Road, NBT 10; Northbrook, IL 60062	847-559-4879		sarah.doyle@caremark.com
933 0393 - Sistemas Medicos Nacionales, S.A.de C.V.	Elizabeth Daniels	933 0393	Katie Coyne
dba: Simnsa Health Care	General Counsel	01/31/2000	Tammy Putnam
Paseo Rio Tijuana #406; Tijuana, BC MEXICO	619-407-4082	Full Service	Jennifer Lum
c/o International Healthcare 303 H Street,Ste. 390; Chula Vista, CA 9	619-407-4087	Sacramento	edaniels@simnsa.com
933 0461 - Talbert Health Plan	Keith Wilson	933 0461	Lily Donn
	President/CEO	04/16/2007	
1665 Scenic Avenue, Suite 100; Costa Mesa, CA 92626	714-436-4890	Full Service	Jennifer Lum
1665 Scenic Avenue, Suite 100; Costa Mesa, CA 92626	714-436-4889		keith.wilson@talbertmedical.com
933 0259 - U. S. Behavioral Health Plan, California	James Davis	933 0259	Elaine Paniewski
	President	11/17/1989	Van Vu
3111 Camino Del Rio North, Suite 800; San Diego, CA 92108	619-641-6933	Psychological	Lorilee Ambrosini
3111 Camino Del Rio North, Suite 800; San Diego, CA 92108	619 641 6227	Sacramento	james.davis@optumhealth.com

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933 0291 - UDC Dental California, Inc.	Frederick Cook	933 0291	Crystal Chen
dba: United Dental Care of California, Inc.	President	12/20/1989	Wendy Jang
3333 Camino Del Rio South, Suite 300; San Diego, CA 92108	800 821-1294	Dental	Hung Truong
3333 Camino Del Rio South, Suite 300; San Diego, CA 92108	619 282-8029	Sacramento	
933 0046 - United Concordia Dental Plans of CA, Inc.	Laurie Laspina	933 0046	Crystal Chen
dba: Mida Dental	Chief Operating Officer	08/30/1979	Van Vu
21700 Oxnard Street, Suite 500; Woodland Hills, CA 91367	818-936-1371	Dental	Hung Truong
P.O. Box 10194; Van Nuys, CA 91410	818 704-9817	Sacramento	laurie.laspina@ucci.com
933 0209 - Universal Care	Chris Mardesich	933 0209	Elizabeth Spring
HMO California	Director of Compliance	10/15/1985	David Weinberg
1600 E. Hill St.; Signal Hill, CA 90806	562 981-4040	Full Service	Jennifer Lum
1600 E. Hill St.; Signal Hill, CA 90806	562 981-5825	Sacramento	cmardesich@universalcare.com
933 0293 - ValueOptions of California, Inc.	Steven Rockowitz	933 0293	Elaine Paniewski
	Exec. Director	12/11/1990	Amy Fong
10805 Holder Street; Cypress, CA 90630	714-763-2427	Psychological	Anna Belmont
10805 Holder Street; Cypress, CA 90630	714-763-2504	Sacramento	steven.rockowitz@valueoptions.com

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933 0329 - Vision First Eye Care, Inc.	James K. Eu	933 0329	Marie Eppler
	President	08/19/1996	Christopher Ermolik
1937-A Tully Road; San Jose, CA 95122	408 923-0400	Vision	Nelly Wei
1937-A Tully Road; San Jose, CA 95122	408 923-3303	Sacramento	drjeu@yahoo.com
933 0268 - Vision Plan of America	Stuart Needleman	933 0268	Marie Eppler
	President	01/30/1987	James Hollister
3255 Wilshire Blvd, Suite 1610; Los Angeles, CA 90010	213 384-2600	Vision	Jessica Tran
3255 Wilshire Blvd, Suite 1610; Los Angeles, CA 90010	213 384-0084	Sacramento	
933 0049 - Vision Service Plan	Patricia C. Cochran	933 0049	Marie Eppler
F: California Vision Service	Chief Financial Officer	02/14/1978	Susan Burger
3333 Quality Drive; Rancho Cordova, CA 95670	916 851-4710	Vision	Barbara Yaklin
3333 Quality Drive; Rancho Cordova, CA 95670	916 851-4850	Sacramento	patrco@vsp.com
933 0287 - VisionCare of California	Nicholas Shashati	933 0287	Marie Eppler
dba: Sterling Visioncare	President, COO	01/26/1989	Amy Fong
9625 Black Mountain Road, Suite 311; San Diego, CA 92126	858 831-9322	Vision	Anna Belmont
9625 Black Mountain Road, Suite 311; San Diego, CA 92126	858 831-0225	Sacramento	vcc@sterlingvisioncare.com

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933 0411 - VMC Behavioral Healthcare Services, Inc	Jean Taylor	933 0411	Elaine Paniewski
VMC Behavioral Healthcare Services; VMC Connect	Executive Director	07/14/2004	Marie Broadnax
450 Dondee Way, Suite #7; Pacifica, CA 94044	(650) 557-9864	Psychological	Daniele Lopes
450 Dondee Way, Suite #7; Pacifica, CA 94044	(650) 355-0862	Sacramento	jeantaylor@vmceap.com
933 0008 - WATTSHealth Foundation, Inc.	Michelle Quartel	933 0008	Nancy Pheng
dba: UHP Healthcare	Consultant	01/30/1978	Grace Jimenez-Hennessy
5959 Century Blvd., Suites 739-741; Los Angeles, CA 90045	310-424-2220	Full Service	Jefferey Roskelley
P.O. Box 5127; Inglewood, CA 90310-5127		Sacramento	quartelm@uhphealthcare.com
933 0224 - Western Dental Services, Inc.	Samuel H. Gruenbaum	933 0224	Crystal Chen
dba: Western Dental Plan, Beauchamp FamilyDental	President / CEO	05/31/1985	Amy Fong
530 So. Main Street; Orange, CA 92868	714 480-3000	Dental	Maryam Tahriri
530 So. Main Street; Orange, CA 92868	714 480-3094	Sacramento	sgruenbaum@westerndental.com
933 0348 - Western Health Advantage	Rebecca Downing	933 0348	Marie Eppler
	Chief Compliance Officer	01/14/1997	Anne Potter
2349 Gateway Oaks, Suite 100; Sacramento, CA 95833	916-563-3183	Full Service	Jessica Tran
2349 Gateway Oaks, Suite 100; Sacramento, CA 95833	916-563-3182	Sacramento	r.downing@westernhealth.com

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933 0429 - Western Health Advantage Community Health Plan-QIF	Rita Ruecker	933 0429	Marie Eppler
WHA Community Health Plan; WHACHP	Chief Financial Officer	06/15/2005	
2349 Gateway Oaks, Suite 100; Sacramento, CA 95833	916-563-3180	QIF	Jessica Tran
2349 Gateway Oaks, Suite 100; Sacramento, CA 95833	916-563-3182		R.Ruecker@westernhealth.com

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