



EL CENTRO REGIONAL MEDICAL CENTER  
BOARD OF TRUSTEES – REGULAR MEETING

MONDAY, March 23, 2026  
5:30 PM

MOB CONFERENCE ROOM 1&2  
1271 ROSS AVENUE, EL CENTRO, CA  
&

**TELECONFERENCE LOCATION NOTE:** Pursuant to Government Code Section 54953(b) Trustee Patty Maysent- CEO, UCSD Health will be attending the Regular Meeting via teleconference from:

JACOBS MEDICAL CENTER, Suite 1-620  
9300 CAMPUS POINT DR.  
SAN DIEGO, CA 92037

**ACTING-PRESIDENT:** Sylvia Marroquin

**MEMBERS:** Sonia Carter; Claudia Camarena; Marty Ellett; Michael Crankshaw; Patty Maysent-CEO, UCSD Health; Christian Tomaszewski-M.D.-CMO, UCSD; Pablo Velez-CEO ECRMC

**CLERK:** Belen Gonzalez

**ATTORNEY:** Douglas Habig, ECRMC Attorney

*This is a public meeting. If you are attending in person, and there is an item on the agenda on which you wish to be heard, please come forward to the microphone. Address yourself to the president. You may be asked to complete a speaker slip; while persons wishing to address the Board are not required to identify themselves (Gov't. Code § 54953.3), this information assists the Board by ensuring that all persons wishing to address the Board are recognized and it assists the Board Executive Secretary in preparing the Board meeting minutes. The president reserves the right to place a time limit on each person asking to be heard. If you wish to address the board concerning any other matter within the board's jurisdiction, you may do so during the public comment portion of the agenda.*

BOARD MEMBERS, STAFF AND THE PUBLIC MAY ATTEND VIA ZOOM.

To participate and make a public comment in person, via Zoom or telephone, please raise your hand, speak up and introduce yourself.

**Join Zoom Meeting:** <https://ecrmc.zoom.us/j/85939213975?pwd=bISZC9heZRrMdKfLFbYoAuuXIuDcmO.1>

**Optional dial-in number:** (669) 444-9171

**Meeting ID:** 859 3921 3975 **Passcode:** 376458

Public comments via zoom are subject to the same time limits as those in person.

### OPEN SESSION AGENDA

#### ROLL CALL:

#### PLEDGE OF ALLEGIANCE:

**PUBLIC COMMENTS:** Any member of the public wishing to address the Board concerning matters within its jurisdiction may do so at this time. Three minutes is allowed per speaker with a cumulative total of 15 minutes per group, which time may be extended by the President. Additional information regarding the format for public comments may be provided at the meeting.

#### BOARD MEMBER COMMENTS

#### CONSENT AGENDA *(Item 1)*

All items appearing here will be acted upon for approval by one motion, without discussion. Should any Board member or other person request that any item be considered separately, that item will be taken up at a time as determined by the President.

1. Review and Approval of Board of Trustees Minutes of Regular Meeting of February 23, 2026—**Action**

**CHIEF EXECUTIVE OFFICER UPDATE**

- 2. Verbal Report from the CEO to the Board of Trustees—**Informational**
- 3. Manager Update—Patty Maysent—**Informational**

**NEW BUSINESS**

- 4. IVHD Medical Staff Application—**Action**
- 5. Medical Staff OPPE Frequency Change—**Action**

**FINANCE and OPERATIONAL UPDATE**

- 6. Review and Approval of the Financial Statements for Month and Year-to-Date as of February 2026—**Action**

**RECESS TO CLOSED SESSION – BOARD PRESIDENT**

- A. **HEARING/DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES.** The Hospital Board will recess to closed session pursuant to Government Code Section 37624.3 for a hearing and/or deliberations concerning reports of the \_\_\_ hospital medical audit committee, or X quality assurance committees, or X staff privileges.
- B. **TRADE SECRETS.** The Hospital Board will recess to closed session pursuant to Govt. Code Section 37606(b) for the purpose of discussion and/or deliberation of reports involving hospital trade secret(s) as defined in subdivision (d) of Section 3426.1 of the Civil Code and which is necessary, and would, if prematurely disclosed create a substantial probability of depriving the hospital of a substantial economic benefit:

<u>Discussion of:</u>	<u>Number of Items:</u>
<u>X</u> hospital service;	<u>1</u>
<u>X</u> program;	<u>1</u>
<u>X</u> hospital facility	<u>1</u>

**RECONVENE TO OPEN SESSION – BOARD PRESIDENT**

**ANNOUNCEMENT OF CLOSED SESSION ACTIONS, IF ANY – GENERAL COUNSEL**

- 7. Approval of Report of Medical Executive Committee’s Credentials Recommendations Report for Appointments, Reappointments, Resignations and Other Credentialing/Privileging Actions of Medical Staff and/or AHP Staff (*Approved in Closed Session*)

**ADJOURNMENT:** Adjourn. (Time: ) Subject to additions, deletions, or changes.



**El Centro Regional Medical Center**  
**BOARD OF TRUSTEES – REGULAR MINUTES**  
**OPEN SESSION MINUTES**  
 MOB CONFERENCE ROOMS 1 & 2  
 1271 Ross Avenue, El Centro, CA 92243

Zoom Meeting link: <https://ecrmc.zoom.us/j/82707223197?pwd=WUpbaL20XbxhNmV2d2frsIT09lIXjx.1>

**Monday, February 23, 2026**

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
<b>ROLL CALL</b>	<p><b>PRESENT:</b> Marroquin; Carter; Camarena; Ellett; Maysent (<i>present @ 6:29pm</i>); Tomaszewski; Chief Executive Officer Pablo Velez; and Executive Board Secretary Belen Gonzalez</p> <p><b>ABSENT:</b> Crankshaw</p> <p><b>VIA Zoom:</b> UCSD Tammy Morita</p> <p><b>ALSO PRESENT:</b> ECRMC Attorney Douglas Habig; ECRMC; Chief of Staff Andrew Lafree, MD</p> <p><b>Hospital Administrative Staff:</b> David Momberg-CFO; Luis Castro-CHRO; Seung Gwon, MD-CMO</p>	
<b>CALL TO ORDER</b>		The Board of Trustees convened in open session at 5:30 p.m. Acting Board President Marroquin called the meeting to order.
<b>OPENING CEREMONY</b>	The Pledge of Allegiance was recited in unison.	None
<b>NOTICE OF MEETING</b>	Notice of meeting was posted and mailed consistent with legal requirements.	None

Regular Meeting  
February 23, 2026 5:30 p.m.

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
<b>PUBLIC COMMENTS</b>	None	None
<b>BOARD MEMBER COMMENTS</b>	None	None
<b>CONSENT AGENDA</b> <i>(Item 1)</i> <b>Item 1. Review and Approval of Board of Trustees Minutes of Regular Meeting of January 26, 206</b>	All items appearing here were acted upon for approval by one motion (or as to information reports, acknowledged receipt by the Board and directed to be appropriately filed) without discussion.	MOTION: by Ellett, second by Carter and carried to approve the Consent Agenda.  All present in favor; none opposed.
<b>CHIEF EXECUTIVE OFFICER UPDATE</b> <b>Item 2. Verbal Report from the CEO to the Board of Trustees—Informational</b>	Item to be discussed in Closed Session	Informational
<b>Item 3. Manager Update—Patty Maysent—Informational</b>	Item to be discussed in Closed Session	Informational.
<b>FINANCE and OPERATIONAL UPDATE</b> <b>Item 4. Review and Approval of the Financial Statements for Month and Year-to-Date as of January 2026.</b>	David Momberg presented the Financial Statements for Month and Year-to-Date as of January 2026 report and answered questions.  Presentation included: <ul style="list-style-type: none"> <li>• Comparative volumes vs. Prior Month/Year</li> <li>• Balance Sheet vs. Prior Month comparison</li> <li>• Operating Statement vs. Prior Month comparison</li> <li>• Monthly Cash Flow (Fiscal Year to Date)</li> </ul>	MOTION: by Carter, second by Marroquin and carried to approve the Financial Statements for Month and Year-to-Date as of January 2026.  All present in favor; none opposed.
<b>RECESS TO CLOSED SESSION</b>		MOTION: by Carter, second by Marroquin and carried to recess to Closed Session at pm for HEARING/ DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES, TRADE

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
		<p>SECRETS, and CONFERENCE WITH LEGAL COUNSEL.</p> <p>All present in favor to recess to Closed Session. None opposed</p>
<p><b>RECONVENE TO OPEN SESSION</b></p>		<p>The Board of Trustees reconvened to Open Session at 6:56pm.</p>
<p><b>ANNOUNCEMENT OF CLOSED SESSION ACTIONS, IF ANY— GENERAL COUNSEL</b></p>		<p><b>[A. HEARING/DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES— GOVERNMENT CODE SECTION 37624.3]</b></p> <p>MOTION: by Ellett, second by Carter and carried to approve the Report of Medical Executive Committee’s Credentials Recommendations Report for Appointments, Reappointments, Resignations and Other Credentialing/Privileging Actions of Medical Staff and/or AHP Staff.</p> <p>All present in favor; none opposed.</p> <p><b>[C. CONFERENCE WITH LEGAL COUNSEL— The Hospital Board recessed to closed session pursuant to Government Code Section 54956.9 (d)(1)—Abdelmuti Claim</b></p> <p>MOTION: by Ellett, seconded by Marroquin and carried to approve the response from ECRMC to Abdelmuti claim</p>

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
		All present in favor; none opposed.
<b>ADJOURNMENT</b>		There being no further business, meeting was adjourned at approximately 6:58pm.

\_\_\_\_\_  
BELEN GONZALEZ, BOARD EXECUTIVE SECRETARY

APPROVED BY

\_\_\_\_\_  
SYLVIA MARROQUIN, ACTING-BOARD PRESIDENT

Regular Meeting  
February 23, 2026 5:30 p.m.



**TO:** ECRMC BOARD MEMBERS

**FROM:** Andrew LaFree, M.D., Chief of Staff

**DATE:** March 23, 2026

**MEETING:** Board of Trustees

**SUBJECT:** IVHD MEDICAL STAFF APPLICATION

**BUDGET IMPACT:**   X   Does not Apply  
 A. Does the action impact/affect financial resources?    Yes   X   No  
 B. If yes, what is the impact amount: \_\_\_\_\_

**BACKGROUND:** In anticipation of the pending merger, the Medical Staff Services Offices of El Centro and Pioneers collaborated to conduct a comprehensive review, comparison, and evaluation of their respective Medical Staff Application. This effort included analyzing existing application formats, credentialing requirements, and verification procedures to identify best practices and ensure consistency across both organizations. Based on this joint assessment, a unified Imperial Valley Healthcare District (IVHD) Medical Staff Application was developed. The revised application is designed to align with all applicable regulatory requirements and accreditation standards, promoting accuracy, efficiency, and compliance in the credentialing process. Implementation of this standardized application will occur upon finalization of the merger, supporting a seamless transition to an integrated medical staff structure.

**DISCUSSION:** The purpose of this Medical Staff Application is to establish a standardized and comprehensive process for the collection, verification, and evaluation of applicant credentials. It is intended to ensure that all practitioners seeking medical staff membership and/or clinical privileges meet the required qualifications, demonstrate professional competence, and adhere to the organization’s standards of care. Additionally, the application supports compliance with regulatory and accreditation bodies, facilitates efficient credentialing and privileging decisions, and promotes consistency and transparency across the organization. The goal of implementing a unified application, is to enhance patient safety, uphold high-quality clinical standards, and streamline administrative processes for both applicants and medical staff services.

**RECOMMENDATION:**   (1) Approve   (2) Do not approve

**ATTACHMENT(S):**

- Imperial Valley Healthcare District (IVHD) Medical Staff Application

Approved for agenda, Chief Executive Officer

Date and Signature:   Pablo Velazquez

[LOGO]

[Date]

Dear «FormalNameWithDegree»,

Thank you for your interest and request for an application for Medical Staff Membership and Clinical Privileges at Imperial Valley Healthcare - El Centro and/or Pioneers campus. The application and delineation of privileges are enclosed, as well as excerpts from the Medical Staff Bylaws.

To prevent delays in the credentialing process, please make sure you answer all questions on the application completely. Give complete contact information, including email addresses, as requested on the application. (See attached page 2, Check List of all required documents.) The processing of your application will begin as soon as we receive the complete application, together with all required documents. The credentialing process may take up to 90-days from the time it begins.

Please be reminded that any and all Adverse notifications, including malpractice cases that are pending, closed, letter of intent, actions regarding Medical Licensure, and any matters involving other facilities (i.e. peer review investigation, suspension of privileges, etc.), **must** be DISCLOSED within 14 days of receipt of notification.

Board Certification.

- Established physicians: Must be board-certified, and are expected to maintain their active certification status.
- New graduates: Are progressing towards certification by; (1) boards which are duly organized and recognized by an American Board of Medical Specialties, or; (2) a board or association with equivalent requirements approved by the Medical Board of California, or; (3) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training program that provides complete training in that specialty or subspecialty. Applicants who are progressing toward board certification must become board certified within five years of the initial granting of medical staff membership.

A non-refundable initial Application Fee is required. See Invoice, page 3, for more details.

Both Campuses: \$600.00.

One campus: \$500.00.

Please feel free to contact the Medical Staff Services Office for any questions:

El Centro Office (760) 339-7203 / Pioneers Office (760)-351-3397.

Sincerely,

Medical Staff Services

Imperial Valley Healthcare District

Attachments: Medical Staff Application and Supplements, Delineation of Privileges, Excerpts Medical Staff Bylaws

**Imperial Valley Healthcare District**  
**MEDICAL STAFF APPLICATION**  
CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT

<b>CHECKLIST</b>	
<b>THE FOLLOWING DOCUMENTS MUST BE RETURNED and/or SUBMITTED TO COMPLETE THE INITIAL APPLICATION PROCESS</b>	
	Application Invoice, Non-refundable fee- 2 campus: \$600.00 / 1 campus: \$500.00 — See INVOICE for details.
	COMPLETED Medical Staff Application, Pages 4-28, returned (this includes referenced Supplements below). All questions must be addressed. If not applicable, indicate N/A.
	Supplement 1 - Professional Liability Action Explanation
	Supplement 2 - Continuing Medical Education Attestation
	Supplement 3 - Health Status
	Supplement 4 - Employee/Physician Security Access Worksheet (2 pages)
	Supplement 5 - Influenza Vaccination form
	Supplement 6 - Medicare Acknowledgement Statement
	Supplement 7 - Physician Preference/Alternate Coverage
	Supplement 8 - Provider Signature Form
	Supplement 9 -Tuberculosis Screening Form, as well as; <ul style="list-style-type: none"> <li>▪Proof of last Quanti FERON-Gold within last 1-year, prior start date.</li> <li>▪If historically positive, Chest x-ray report.</li> </ul>
	Supplement 10- Signed Current Activity Request
	Supplement 11- Education Module Acknowledgement
	Supplement 12- Electronic Prescriptions Controlled Substances Education Module
<b>Additional documentation needed - to avoid delays:</b>	
	Documentation of all past and present educational and practice experience beginning with medical school. Please include Program Directors contact information with phone and email address if less than 3 years ago. <u>Important:</u> On a separate page clarify any unaccounted time, or GAP in time period from medical school to present.
	Delineation of Privilege form, completed, signed, dated. (Sent with application packet.)
	Moderate Sedation privileges <u>requires successful completion of an examination.</u> Inform us immediately if you desire these privileges, we will provide you with the appropriate examination(s) for completion.
	Submit copy of current Curriculum Vitae
	Submit copy of ECFMG Certificate (if applicable)
	Submit copy of current CPR/PALS/ACLS/BLS certificates (If applicable per qualifications/privileges requested)
	Submit copy of current Fluoroscopy Certificate (as applicable)
	Submit copy of current DEA Certificate
	Submit copy of current State Medical License
	Submit copy of current Board Certification Certificate
	Submit copy of current Certificate of Insurance
	Current photo within the past two years (Must be government issued, i.e., CDC, Passport, etc.)

**IMPORTANT: All Practitioners are required to participate in the Physician Onboarding / Orientation Program prior to their start date. Expect a communication from us approximately 2 to 7 days following your approval, so you can be scheduled to come in for this process.**

*Thank you for your interest in Imperial Valley Healthcare District!*

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT

[LOGO]

Date:

**INVOICE**

From: Medical Staff of Imperial Valley Healthcare District

# Create IDNumber

To: «FormalNameWithDegree»

A non-refundable Application Fee is required.

- Both campuses: \$600.00. With Pre-Application fee of, \$300.00, already paid, the remaining balance is due and payable upon return of the Initial Application.
- One campus: \$500.00. Same as above, with Pre-Application fee of \$250.00, already paid, the remaining balance is due and payable upon return of the Initial Application.

**CHECK ACCORDINGLY:**

I am applying to:	<input type="checkbox"/> El Centro Campus	<input type="checkbox"/> Pioneers Campus	<input type="checkbox"/> Both Campuses
My PRIMARY campus will be:	<input type="checkbox"/> El Centro Campus	<input type="checkbox"/> Pioneers	

Please make check payable to PRIMARY campus: IVHD, Medical Staff - El Centro Campus OR Pioneers Campus

Address: IVHD, El Centro Hospital / 1415 Ross Street, El Centro, CA / 92243  
IVHD, Pioneers Hospital / 207 W Legion Rd, Brawley, CA / 92227

PHYSICIAN NAME:	Description	Application Fee:
«FormalNameWithDegree»	Application Fee	
<b>Total:</b>		

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT

CONFIDENTIAL/PROPRIETARY

**INITIAL APPLICATION**

**PLEASE CHECK BELOW ACCORDINGLY**

- I hereby apply to the Medical Staff of IVHD:     El Centro Campus     Pioneers Campus     Both Campuses
- My PRIMARY campus:                             El Centro Campus     Pioneers Campus

**INSTRUCTIONS** - This form should be typed or legibly printed in black or blue ink. If more space is needed than provided, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. All fields MUST be completed. Missing information will result in delays.

**I. IDENTIFYING INFORMATION**

Last Name: « <b>LastName</b> »	First: « <b>FirstName</b> »	Middle: « <b>MiddleName</b> »	Degree: « <b>Degree</b> »
Is there any other name under which you have been Known? Name (s):			
Home Mailing Address: « <b>HomeAddress</b> »		Home Telephone Number: « <b>CellPhone</b> »	
City: « <b>HomeAddressCity</b> »		Home Fax Number:	
State: « <b>HomeAddressState</b> »	Zip: « <b>HomeAddressZip</b> »	Email: « <b>Email</b> »	
Birth Date: « <b>BirthDate</b> »		Citizenship: « <b>Citizen</b> » (If not a United States citizen, please include copy of Alien Registration Card)	
Birth Place (City/State/Country):« <b>HomeAddressCounty</b> » « <b>BirthPlace</b> »		Race/Ethnicity (voluntary):	
Marital Status: (Optional) <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED		Pager Number:	
Social Security Number: « <b>SSN</b> »		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Prefer not to state	

**II. PRACTICE INFORMATION**

Specialty: « <b>Specialty1</b> »	Subspecialty: « <b>Specialty2</b> »
Practice Name (if applicable): « <b>Office1MedicalGroup</b> »	
Primary Office Street Address: « <b>Office1Address</b> »	Secondary Office Street Address: « <b>OFFICE2Address</b> »
City: « <b>Office1AddressCity</b> »	City: « <b>OFFICE2AddressCity</b> »
State: « <b>Office1AddressState</b> »	State: « <b>OFFICE2AddressState</b> »
Zip: « <b>Office1AddressZip</b> »	Zip: « <b>OFFICE2AddressZip</b> »
Email: « <b>Office1AddressEmail</b> »	
Email: « <b>OFFICE2AddressEmail</b> »	
Telephone Number: « <b>Office1AddressTelephone</b> »	
Telephone Number: « <b>OFFICE2AddressTelephone</b> »	
Fax Number: « <b>PrimaryAddressFax</b> »	
Fax Number: « <b>SecondaryAddressFax</b> »	
Office Manager/Administrator:	
Office Manager/Administrator:	
Name Affiliated with Tax ID Number:	
Name Affiliated with Tax ID Number:	
Federal Tax ID Number:	
Federal Tax ID Number:	

**Imperial Valley Healthcare District  
MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

<b>III. PREMEDICAL EDUCATION</b>		
College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
E-Mail Address:	State:	ZIP:
<b>IV. MEDICAL/PROFESSIONAL EDUCATION</b>		
Medical/Professional School: « <b>EDUCATIONMEDICALEDUCATION1Name</b> »	Degree Received: « <b>MEDICALEDUCATION1EndDate</b> »	Date of Graduation: (mm/yy)
Mailing Address: « <b>MEDICALEDUCATION1Address</b> »	City: « <b>MEDICALEDUCATION1City</b> »	
	State/ Country: « <b>MEDICALEDUCATION1State</b> »	ZIP: « <b>MEDICALEDUCATION1Zip</b> »
<b>V. INTERNSHIP/PGYI</b> <i>(Use additional separate page if necessary)</i>		
Name of Institution: « <b>INTERNSHIP1Name</b> »	Type of Internship:	Specialty:
Mailing Address: « <b>INTERNSHIP1Address</b> »	From: (mm/yy) « <b>INTERNSHIP1StartDate</b> »	To: (mm/yy) « <b>INTERNSHIP1EndDate</b> »
City/State/ ZIP: « <b>INTERNSHIP1City</b> », « <b>INTERNSHIP1State</b> », « <b>INTERNSHIP1Zip</b> »	Name of Program Director:	
Graduate Medical Education Office: Email: _____ Phone: _____	Program Director Contact Information: Email: _____ Phone: _____	
DID YOU SUCCESSFULLY COMPLETE THE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO    (If NO, please explain on separate page.)		
<b>VI. RESIDENCY / FELLOWSHIP</b> <i>(Use additional separate page if necessary)</i>		
Include residencies, fellowships, preceptorship, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, give name, address, city and ZIP code, and dates. Include all programs you attended, whether or not completed.		
Name of Institution: « <b>RESIDENCY1Name</b> »	Type of Training (e.g. residency, etc.): <b>Residency</b>	Specialty:
Mailing Address: « <b>RESIDENCY1Address</b> »	From: (mm/yy) « <b>RESIDENCY1StartDate</b> »	To: (mm/yy) « <b>RESIDENCY1EndDate</b> »
City/State/Zip: « <b>RESIDENCY1City</b> », « <b>RESIDENCY1State</b> », « <b>RESIDENCY1Zip</b> »	Name of Program Director:	
Graduate Medical Education Office: Email: _____ Phone: _____	Program Director Contact Information: Email: _____ Phone: _____	
DID YOU SUCCESSFULLY COMPLETE THE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO    (If "No," please explain on separate sheet.)		
Name of Institution: « <b>FELLOWSHIP1Name</b> »	Type of Training (e.g. residency, etc.): <b>Fellowship</b>	Specialty:
Mailing Address: « <b>FELLOWSHIP1Address</b> »	From: (mm/yy) « <b>FELLOWSHIP1StartDate</b> »	To: (mm/yy) « <b>FELLOWSHIP1EndDate</b> »
City/State/Zip: « <b>FELLOWSHIP1City</b> », « <b>FELLOWSHIP1State</b> », « <b>FELLOWSHIP1Zip</b> »	Name of Program Director:	
Graduate Medical Education Office: Email: _____ Phone: _____	Program Director Contact Information: Email: _____ Phone: _____	
DID YOU SUCCESSFULLY COMPLETE THE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO    (If "No," please explain on separate sheet.)		

**Imperial Valley Healthcare District  
MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

**VII. BOARD CERTIFICATION**

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

- A member board of the American Board of Medical Specialties (ABMS); ➤ A member board of the American Osteopathic Association (AOA); ➤ A board or association with equivalent requirements approved by the Medical Board of California; ➤ A board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

**NOT BOARD CERTIFIED.** If not board certified, provide date(s) of certification eligibility, and your intent for certification, and on separate sheet.

**BOARD CERTIFIED, as follows:**

Name of Issuing Board:	Specialty:	Date Certified/Recertified:	Expiration Date (if any):
« <b>BOARDCERTIFICATION1 Name</b> »	« <b>BOARDCERTIFICATION1Cert ifiedIn</b> »	« <b>BOARDCERTIFICATION1InitialCert ification</b> »	« <b>BOARDCERTIFICATION1Ex prDate</b> »
« <b>BOARDCERTIFICATION2 Name</b> »	« <b>BOARDCERTIFICATION2Cert ifiedIn</b> »	« <b>BOARDCERTIFICATION2InitialCert ification</b> »	« <b>BOARDCERTIFICATION2Ex prDate</b> »

Have you applied for board certification other than those indicated above?  NO  YES - If YES, list board(s) and date(s) below:


**VIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, ACLS, etc.)**

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

**IX. MEDICAL LICENSURE/REGISTRATIONS**

California State Medical License Number: « <b>0101Number</b> »	Issue Date: « <b>0101Issued</b> »	Expiration Date: « <b>0101Expired</b> »
Drug Enforcement Administration (DEA) Registration Number: « <b>DEA1Number</b> »	Expiration Date: « <b>DEA1Expired</b> »	
Fluoroscopy, X-ray Supervisor and Operator License Number: « <b>X-RAY-RAD1Number</b> »	Expiration Date: « <b>X-RAY-RAD1Expired</b> »	
Controlled Dangerous Substances Certificate (CDS) (if applicable):	Expiration Date:	
ECFMG Number (applicable to foreign medical graduates):	Date Issued/ Valid Through:	
National Physician Identifier (NPI): « <b>NPI</b> »	Medicaid Number:	
Medicare UPIN:	MediCal Number:	

**X. ALL OTHER STATE MEDICAL LICENSES - List ALL current Medical Licenses AND ALL previously held Medical Licenses. (Use additional separate page if necessary.)**

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

**Imperial Valley Healthcare District  
MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

<b>XI. PROFESSIONAL LIABILITY – Attach current Certificate of Insurance</b>			
<b>CURRENT Insurance Carrier</b> - Please explain any surcharges to your professional liability coverage on a Separate sheet.			
<b>«Insurance1Name»</b>	Policy No: <b>«Insurance1PolicyNumber»</b>	Effective date: <b>«Insurance1IssuedDate»</b>	Expiration Date: <b>«Insurance1Expr Date»</b>
Mailing Address: <b>«Insurance1Address»</b>	Per Claim Amount:	Aggregate Amount:	
City/State/Zip: <b>«Insurance1City» «Insurance1State» «Insurance1Zip»</b>	Carrier Phone: <b>«INSURANCE1Telephone »</b>	Carrier Fax: <b>«INSURANCE1Fax»</b>	
Carrier Email: <b>«INSURANCE1Email»</b>			
<b>PAST Insurance Carrier</b> - List all other professional liability carriers <u>within the past ten years</u> , in reverse chronological order. Time GAPS in coverage must be explained on a separate page.			
<b>Past Insurance Carrier:</b> <b>«INSURANCE2Name»</b>	Policy No: <b>«INSURANCE2PolicyNumber »</b>	Effective date: <b>«INSURANCE2IssuedDate»</b>	Expiration Date: <b>«INSURANCE2ExpirationDate»</b>
Mailing Address: <b>«INSURANCE2Address»</b>	Per Claim Amount:	Aggregate Amount:	
City/State/Zip: <b>«INSURANCE2City», «INSURANCE2State», «INSURANCE2Zip»</b>	Carrier Phone: <b>«INSURANCE2Telephone»</b>	Carrier Fax: <b>«INSURANCE2Fax»</b>	
Carrier Email:			
<b>Name Past Insurance Carrier:</b>	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			
<b>Name Past Insurance Carrier:</b>	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			
<b>Name Past Insurance Carrier:</b>	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			
<b>Name Past Insurance Carrier:</b>	Policy No:	Effective date:	Expiration Date:
Mailing Address:	Per Claim Amount:	Aggregate Amount:	
City/State/Zip:	Carrier Phone:	Carrier Fax:	
Carrier Email:			

*(Use separate page if more space needed for Past Insurance Carrier)*

**Imperial Valley Healthcare District  
MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

**XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS**

List in reverse chronological order, (your most current affiliation first), all institutions where you have current affiliation and/or maintain privileges. This includes hospitals, clinics, surgery centers, institutions, corporations, military assignments or government agencies, (*use separate page if needed*). **NOTE: If you do NOT currently maintain have hospital privileges, please EXPLAIN on separate page.**

<b>Hospital Name:</b>	Department/Status (Active, Courtesy, etc.):	Appointment Date:
Address/ City/State/ZIP:	Phone: _____ Fax: _____	Email:
<b>Hospital Name:</b>	Department/Status (Active, Courtesy, etc.):	Appointment Date:
Address/ City/State/ZIP:	Phone: _____ Fax: _____	Email:
<b>Hospital Name:</b>	Department/Status (Active, Courtesy, etc.):	Appointment Date:
Address/ City/State/ZIP:	Phone: _____ Fax: _____	Email:
<b>Hospital Name:</b>	Department/Status (Active, Courtesy, etc.):	Appointment Date:
Address/ City/State/ZIP:	Phone: _____ Fax: _____	Email:

**XIV. PREVIOUS AFFILIATIONS – During the past TEN (10) years**

List previous affiliations during past TEN (10) Years. This would include any of the following entities you are no longer affiliated with - hospitals, surgery centers, other institutions, corporations, military assignments, or government agencies. (*Use separate page if needed.*)

<b>Hospital Name:</b>	Department/Status (Active, Courtesy, etc.):	Appointment Date:
Address/ City/State/ZIP:	Phone: _____ Fax: _____	Email:
Reason For Leaving:		
<b>Hospital Name:</b>	Department/Status (Active, Courtesy, etc.):	Appointment Date:
Address/ City/State/ZIP:	Phone: _____ Fax: _____	Email:
Reason For Leaving:		
<b>Hospital Name:</b>	Department/Status (Active, Courtesy, etc.):	Appointment Date:
Address/ City/State/ZIP:	Phone/Fax:	Email:
Reason For Leaving:		
<b>Hospital Name:</b>	Department/Status (Active, Courtesy, etc.):	Appointment Date:
Address/ City/State/ZIP:	Phone: _____ Fax: _____	Email:
Reason For Leaving:		

**Imperial Valley Healthcare District  
MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

**XV. PROFESSIONAL PEER REFERENCES**

Please list three (3) professional peer references, preferably not partners or relatives, who through recent observation (within the past 2-years), have personal knowledge of, and are directly familiar with your professional competence, conduct and work. At least one peer reference should be in your same professional discipline.

Name of Reference: «PEERREFERENCE1Name»		Specialty:
E-mail: «PEERREFERENCE1Email»	Fax Number: «PEERREFERENCE1Fax»	Telephone Number: «PEERREFERENCE1Telephone»
Name of Reference: «PEERREFERENCE2Name»		Specialty:
E-mail: «PEERREFERENCE2Email»	Fax Number: «PEERREFERENCE2Fax»	Telephone Number: «PEERREFERENCE2Telephone»
Name of Reference: «PEERREFERENCE3Name»		Specialty:
E-mail: «PEERREFERENCE3Email»	Fax Number: «PEERREFERENCE3Fax»	Telephone Number: «PEERREFERENCE3Telephone»

**XVI. WORK HISTORY - Please submit a current Curriculum Vitae.**

Chronologically list all work history activities since completion of postgraduate training. This information must be complete. (Use separate page as needed.) **NOTE: Any GAPS in professional work history must be explained on a separate page.**

Name of Practice Employer:	Email Address:	
Contact Name:	Telephone Number:	Fax Number:
From: (mm/yy)	To: (mm/yy)	
Name of Practice Employer:	Email Address:	
Contact Name:	Telephone Number:	Fax Number:
From: (mm/yy)	To: (mm/yy)	
Name of Practice Employer:	Email Address:	
Contact Name:	Telephone Number:	Fax Number:
From: (mm/yy)	To: (mm/yy)	
Name of Practice Employer:	Email Address:	
Contact Name:	Telephone Number:	Fax Number:
From: (mm/yy)	To: (mm/yy)	
Name of Practice Employer:	Email Address:	
Contact Name:	Telephone Number:	Fax Number:
From: (mm/yy)	To: (mm/yy)	

**Imperial Valley Healthcare District  
MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

APPLICANT HERE: «FormalNameWithDegree»

<b>XVI. ATTESTATION QUESTIONS</b>		
<b>IMPORTANT: Please answer the following questions CAREFULLY and COMPLETELY. If your answer to any question is YES, please provide full details on an added separate page. Failure to provide an accurate and complete response to any of the below questions may be grounds for denial of your application.</b>	<b>NO</b>	<b>YES</b>
<b>A.</b> Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration, in any jurisdiction, ever been: Denied, Limited, Restricted, Suspended, Revoked, Not Renewed, Adversely acted upon, Subject to Probationary Conditions, OR, Have you Voluntarily or Involuntarily Relinquished any such License or Registration, OR, Voluntary or Involuntarily Accepted any such Actions or Conditions, OR, Have you been fined or received a letter of reprimand, OR, are any such action(s) pending?	<input type="checkbox"/>	<input type="checkbox"/>
<b>B.</b> Have you <u>ever been</u> : Charged, Suspended, Fined, Disciplined, Otherwise Sanctioned, Subjected To Probationary Conditions, Restricted Or Excluded, Have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct or breach of contract or program conditions, by Medicare, Medicaid, or any public program, OR, are any such action(s) pending?	<input type="checkbox"/>	<input type="checkbox"/>
<b>C.</b> Have your clinical privileges, membership, contractual participation or employment by any medical organization, e.g.: hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), preferred provider organization, private payer, (including those that contract with public programs), medical society, professional association, medical school faculty position, other health delivery entity or system, <u>ever been</u> : Denied, Suspended, Restricted, Reduced, Subject to probationary conditions, Revoked or Not Renewed or Voluntarily Terminated, Reduced or Limited for possible incompetence, improper professional conduct or breach of contract, OR, Is any such above-described action pending?	<input type="checkbox"/>	<input type="checkbox"/>
<b>D.</b> While under investigation for possible incompetence or improper professional conduct or breach of contract, or in return for such an investigation not being conducted <u>have you ever</u> : Surrendered, Allowed to Expire, Voluntarily or Involuntarily Withdrawn a request for Membership or Clinical Privileges, Terminated contractual participation or employment, Resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system, OR, Is any such action pending?	<input type="checkbox"/>	<input type="checkbox"/>
<b>E.</b> Have you <u>ever</u> surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	<input type="checkbox"/>	<input type="checkbox"/>
<b>F.</b> Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, OR, Is any such action pending?	<input type="checkbox"/>	<input type="checkbox"/>
<b>G.</b> Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certify)?	<input type="checkbox"/>	<input type="checkbox"/>
<b>H.</b> Have you ever been convicted of <u>any</u> crime (other than a minor traffic violation)?	<input type="checkbox"/>	<input type="checkbox"/>
<b>I.</b> Do you presently use any drugs illegally?	<input type="checkbox"/>	<input type="checkbox"/>
<b>J.</b> Have any judgments been entered against you, or settlements been agreed to by you <u>within the last ten (10) years</u> , in professional liability cases, or <u>are there any</u> filed and served professional liability lawsuits/arbitrations against you <u>pending</u> ?	<input type="checkbox"/>	<input type="checkbox"/>
<b>K.</b> Has your professional liability insurance ever been: Terminated, Not Renewed, Restricted, Modified (e.g. reduced limits, restricted coverage, surcharged), Placed in a higher Risk Category, OR, Have you ever been Denied Professional Liability Insurance, OR, Has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, Limit your professional liability insurance or its coverage of any procedures?	<input type="checkbox"/>	<input type="checkbox"/>
<b>L.</b> Are there any pending or completed administrative agency, government, or court cases, decisions or judgements involving allegations that you violated any criminal law (excluding minor traffic violations), or failed to comply with laws, statutes, regulations or other legal requirements which may be applicable to the practice of your profession or to your rendition or service to patients?	<input type="checkbox"/>	<input type="checkbox"/>
<b>M.</b> Are there any prior or pending government agency or third party payer proceedings or litigation, challenging or sanctioning your patient admission, treatment, discharge, charging, collection or utilization practices, including but not limited to, Medicare and Medi-Cal fraud and abuse proceedings or convictions?	<input type="checkbox"/>	<input type="checkbox"/>

**ATTESTATION QUESTIONS**

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Imperial Valley Healthcare District  
MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

APPLICANT HERE: «FormalNameWithDegree»

**XVII. INFORMATION RELEASE**

INITIAL

	I authorize the Imperial Valley Healthcare District, (this Healthcare Organization), and its representatives, during the credentialing and recredentialing evaluation process, to consult with any third party (e.g. hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, licensing authorities, background check company, professional liability insurance companies, and other businesses and individuals acting as their agents), to enable a complete and thorough evaluation of my qualifications for medical staff membership and/or privileges.
	I hereby consent to the disclosure, right to inspection and copying of information and documents, recommendations, reports, statements, or disclosures relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, licensing authorities, background check company, and businesses and individuals acting as their agents, professional liability insurance companies, for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, clinical competence, judgement, character, conduct, ethics, mental or emotional stability, physical condition, ability to work with others, and any other matter bearing on my qualifications for appointment to the Medical Staff of clinical privileges. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.
	I authorize the release and exchange of information between my current and former Professional Liability Carrier(s) and this Healthcare Organization, and I request my carrier(s) to send to the Hospital a certificate of insurance that includes coverage for which insurance is afforded, limits of liability, policy number, issue date, expiration date, type of insurance, and full details regarding claims history. I authorize my carrier to notify the Hospital of any changes, reductions in coverage, termination of coverage or failure to renew coverage within 30-days of cancellation of coverage. I release from liability, to the fullest extent allowed by law, all representatives of such Professional Liability Insurance companies for their acts performed in supplying information to the Medical Staff of the Hospital.
	I hereby agree to extend immunity to, release from liability, and agree not to sue this Healthcare Organization, its authorized representatives, and any third parties as described above for any actions, recommendations, reports, statements, communications, or disclosures involving me and related to the evaluation of this application, any subsequent applications for reappointment or clinical privileges, or my professional performance as a member of the Medical Staff.
	I acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation, to the extent that those acts and/or communications are protected by state or federal law.
	I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et.seq., if applicable.
	I understand that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, other qualifications, and for resolving any doubt about such qualifications.

**INFORMATION RELEASE**

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

*THIS RELEASE IS VALID FOR TWO (2) YEARS FROM THE DATE OF ABOVE SIGNATURE*

**Imperial Valley Healthcare District  
MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

**Applicant Name: «FormalNameWithDegree»**

**XVIII. ACKNOWLEDGMENTS, AGREEMENTS**

INITIAL	
	I agree to update the application should there be any change in the information provided in, or in connection with, this application during such time as this application is being processed. I specifically agree to notify the Medical Staff immediately in writing of the occurrence of any of the following: (i) any suspension, revocation or non-renewal of my license to practice medicine in California; (ii) any suspension, revocation or non-renewal of my DEA or other controlled substances registration; (iii) any cancellation or non-renewal of my professional liability insurance coverage; (iv) any exclusion from the Medicare, Medi-Cal or other federal healthcare program; (v) any adverse action related to your clinical privileges or membership at any healthcare organization.
	I agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of receipt of written or oral notice of any adverse action against me, including: <ul style="list-style-type: none"> <li>(i) the Medical Board of California taken or pending, including but not limited to: Any accusation filed; Temporary Restraining Order; Imposition of any Interim Suspension; Probation; Limitations affecting my license to practice medicine;</li> <li>(ii) Any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, Osteopathic Medical Board of California, or a report with the National Practitioner Data Bank; any revocation of DEA license; any formal charge of any crime; any action against any certification under the Medicare or Medicaid programs; or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.</li> <li>(iii) The denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges;</li> <li>(iv) Any material reduction in my professional liability insurance coverage;</li> <li>(v) Receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action;</li> <li>(vi) Conviction of any crime (excluding minor traffic violations);</li> <li>(vii) Receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.</li> </ul>
	I understand that the Medical Staff and Hospital together constitute an Organized Health Care Arrangement with respect to the use and disclosure of patient information under the Health Insurance Portability and Accountability Act (HIPAA), and I agree to maintain the confidentiality and security of patient information consistent with the Medical Staff Rules and Regulations, with Hospital and Medical Staff polices, with the Hospital's Notice of Privacy Practices, and with applicable law, including HIPAA
	I acknowledge that I have received and had the opportunity to review the Medical Staff Bylaws, Rules and Regulations. I agree to be bound by the Bylaws, Rules and Regulations and policies and procedures of the Medical Staff and the Hospital in all matters.
	I agree that if an adverse recommendation or decision is made with respect to my application in any respect, I will exhaust the administrative remedies afforded by the Bylaws and Rules and Regulations of the Medical Staff and this Hospital before resorting to legal action in the courts.
	I agree to appear if requested before Healthcare Organization officers, department officers, and committees for interviews or inquiries regarding this appointment application.
	I agree, if granted membership and/or privileges, to maintain an ethical practice, to provide for continuous care of all my patients, and to abide by the Healthcare Organization medical staff bylaws, policies and rules and to discharge Healthcare Organization functions for which I will be responsible due to my membership, privileges, employment or participation.
	I agree to provide copies of patient's records from another health facility or my private office upon the request of the Healthcare Organization, if in the course of evaluation of my application, my practice at the facility, or office, is deemed relevant.
	I agree to be bound by the terms of the Healthcare Organization medical staff bylaws, policies and rules in all matters relating to the consideration of this appointment application, and to agree that I will complete all hearings and appeals for any adverse membership, privileges, employments or participation action before resorting to court.

**ACKNOWLEDGMENTS, AGREEMENTS**

**APPLICANT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**

**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**

**Applicant Name: «FormalNameWithDegree»**

**XIX. CONFIDENTIALITY**

Initial

	I acknowledge and agree to maintain the confidentiality of all information including, but not limited to, deliberations, discussions, and other records and proceedings, of the medical staff committees (including standing and special committees and departments), and other committees and departments of the hospital which have responsibility for peer review or other activities for the evaluation and improvement of the quality of care rendered in the hospital, the reduction of morbidity or mortality, or assuring proper utilization.
	I acknowledge and agree to maintain the confidentiality of: (1) All information pertaining to medical and certain other personal information about patients; (2) Medical and certain other information about employees; (3) Proprietary information about employees; (3) Proprietary information (this information may be on any media including but not limited to computer information, paper records, microfiche, x-rays, videotape and e-mail); (4) Reports, policies and procedures, marketing or financial information, and other information related to the business or services of the Healthcare Organization and its affiliates which has not been previously been released to the public at large by a duly authorized representative.
	I understand that I may be issued a unique password for accessing computerized information. The password will be changed periodically to prevent unlawful access of data. I acknowledge the following; (1) That my password may give access to a broad patient base; (2) I am only permitted to access information on a need to know basis, i.e. the specific patient account, record, etc. that I require to perform my duties, (3) I am obligated to hold confidential information in the strictest confidence and not to disclose the information to any person or in any manner; (4) My confidentiality obligation shall continue indefinitely, including all times after my association with the Healthcare Organization and its affiliates, such as termination of my staff membership privileges; (5) That if I am issued a unique user code, it is my responsibility to maintain the code in a confidential manner; (6) That without explicit written authorization, no documents or data may leave premises or systems.

**CONFIDENTIALITY - SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**

CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT

Applicant Name: «FormalNameWithDegree»

<b>XX. CONFIDENTIAL &amp; PROTECTED MEDICAL STAFF PEER REVIEW INFORMATION</b> (Pursuant to California Evidence Code Section 1157)
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**As a member of the Medical Staff of Imperial Valley Healthcare District, this acknowledgement shall be signed every two-years.**

**I acknowledge and agree to maintain the confidentiality** of all information including, but not limited to, deliberations, discussions, and other records and proceedings, of the medical staff committees (including standing and special committees and departments), and other committees and departments of the hospital which have responsibility for peer review or other activities for the evaluation and improvement of the quality of care rendered in the hospital, the reduction of morbidity or mortality, or assuring proper utilization.

**I agree to make no voluntary disclosures** of such information except to persons authorized to receive it in the conduct of medical staff and hospital affairs, unless such disclosure is expressly mandated by law. I recognize that maintenance of confidentiality of such information is necessary to promote free and candid discussion, which is essential to assuring the effectiveness of peer review, and other activities related to evaluating, improving, and maintaining the quality and efficiency of patient care. Furthermore, my participation in such medical staff and hospital peer review and quality assurance activities is in reliance on my belief that the confidentiality of the activities will be preserved by every other member of the medical staff or other individual involved.

**I understand that unauthorized disclosure** of such confidential information shall be deemed disruptive of operations, detrimental to the delivery of quality patient care, and a violation of the medical staff bylaws, and therefore shall be grounds for corrective action against me. I further understand that the hospital may also seek injunctive relief in court in order to prevent to terminate threatened or actual unauthorized disclosure of such confidential information or may undertake such other action as it deems appropriate to assure that such confidentiality is maintained.

CONFIDENTIAL & PROTECTED MEDICAL STAFF  
PEER REVIEW INFORMATION

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**

***CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT***

Applicant Name: «FormalNameWithDegree»

**XXI. APPLICATION SIGNATURE**

- I hereby attest that I have reviewed the information contained in or otherwise submitted as part of this application, and I confirm that this information is complete and accurate to the best of my knowledge, that it is submitted in good faith, and that it fairly represents the current level of my training, experience, capability and competence to exercise the privileges for which I have applied.
- I hereby attest that I agree to update my application in writing should there be any change in the information provided or should I receive any other information that would be material to the consideration of my application.
- I hereby attest that I understand that any material misrepresentation, misstatement in, or omission from my application shall, of itself alone, constitute cause for denial of requested membership and/or privileges.
- I hereby attest that I understand that in the event that any misrepresentation, misstatement or omission is discovered after the granting of membership and/or privileges, it shall constitute cause for immediate revocation of such membership and/or all privileges.

Application Signature

SIGNATURE APPLICANT: \_\_\_\_\_

DATE: \_\_\_\_\_

**Imperial Valley Healthcare District**  
**MEDICAL STAFF APPLICATION**  
**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**  
**PROFESSIONAL LIABILITY ACTION EXPLANATION**  
**SUPPLEMENT 1**

*\*Return with your application\**

Please complete a history of your malpractice coverage on this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this (2-page) Addendum B prior to completing, and complete separate forms for each lawsuit.

**I. IDENTIFYING INFORMATION**

Last Name: <b>«LastName»</b>	First: <b>«FirstName»</b>	Middle: <b>«MiddleName»</b>
Street Address:	City:	State:
		ZIP

**II. CASE INFORMATION**

City, County and State where lawsuit filed:	Court case number, if known:
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:
	Sex of patient:
	Age of patient:
Location of Incident: <input type="checkbox"/> Hospital <input type="checkbox"/> My office <input type="checkbox"/> Other doctor's office <input type="checkbox"/> Surgery Center <input type="checkbox"/> Other, (please specify):	

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

---

Is/was there an insurance company or other, liability protection company or organization providing coverage/defense of the lawsuit or arbitration action?       Yes       No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization:

---

If you would like us to contact your attorney regarding any of the above, please provide contact information to include: attorney name, email, and phone number. **Please fax this document to your attorney as this will serve as your authorization.**

Name:	Phone:	Email:
-------	--------	--------

**III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (Attach court documents)**

Lawsuit/arbitration still ongoing, unresolved.

Judgment rendered and payment was made on my behalf. Amount paid on my behalf: \_\_\_\_\_

Judgment rendered and I was found not liable. (Attach court document.)

Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: \_\_\_\_\_

Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

**IV. SUMMARY OF CASE (Attach separate additional page(s) as needed.)**

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. Include: (1) Condition and diagnosis at time of incident; (2) Dates and description of treatment rendered; (3) Condition of patient subsequent to treatment.

I certify that the information in this PROFESSIONAL LIABILITY ACTION EXPLANATION and any attached documents is true and correct. I agree that 'this Healthcare Organization', its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document. I hereby give permission to release to this Healthcare Organization information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing

**PROFESSIONAL LIABILITY ACTION EXPLANATION**

**APPLICANT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT

**HEALTH STATUS**

**Supplement 3**

*\*Return this page with your application\**

IDENTIFYING INFORMATION		
Last Name: <b>«LastName»</b>	First: <b>«FirstName»</b>	Middle: <b>«MiddleName»</b>

- Medical staff members are accountable for their well-being, self-care is patient care.
- All members shall have the right to access confidential mental and physical healthcare support.
- Seeking care will not result in punitive medical staff administrative action.
- Communication and support are critical, therefore, an established physician member will be available for this purpose.
- This medical staff offers a safe-haven and non-reporting option to the provider who is under treatment, and in good standing, of a recognized healthcare program, or other appropriate care provider.

**CIRCLE ONE**

1. Do you have a physical, mental or emotional condition which adversely affects your practice?	NO	YES
2. Are you currently suffering from any condition for which you are not being appropriately treated that impairs you judgement or that would otherwise adversely affect your ability to practice medicine in a competency ethical and professional manner? If you are currently enrolled in a physician health program, you may answer NO.	NO	YES
3. Do you take any medication or drugs (legal/illegal) which adversely affects your ability to perform your duties as they related to the practice of medicine in a competent, ethical and professional manner?	NO	YES
4. Are you currently using illegal drugs including non-prescribed prescription medication?	NO	YES

**INITIALS**

<b>I hereby attest to no current physical, mental, or behavioral health conditions that currently impair my ability to practice medicine with or without reasonable accommodations.</b>	
---	--

Health Status-

Applicant Signature \_\_\_\_\_ DATE \_\_\_\_\_

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
*CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT*  
**EMPLOYEE / PHYSICIAN SECURITY ACCESS WORKSHEET**  
*Valid for: EL CENTRO & PIONEERS Medical Staff*  
**Supplement 4**  
*\*Return this page with your application\**

**1. IDENTIFYING INFORMATION**

Last Name: <<LastName>>	First Name: <<FirstName>>	Middle Name: <<MiddleName>>
Employee ID: (NA FOR PHYSICIAN)	Job Code: (NA FOR PHYSICIAN)	Date Requested:
Job Title: MEDICAL STAFF MEMBER		Facility: <input type="checkbox"/> EL CENTRO <input type="checkbox"/> PIONEERS
Dept. #: (NA FOR PHYSICIAN)	Dept. Name: (NA FOR PHYSICIAN)	
Supervisor Name: MEDICAL STAFF SERVICES OFFICE STAFF		Supervisor Phone: MEDICAL STAFF SERVICES OFFICE

**2. SOFTWARE APPLICATIONS**

Check all applications required by employee. Indicate an existing user in the 'Copy User Access' field. The new user will inherit the existing user's privileges for that application.

Copy User Access: \_\_\_\_\_

CLINICAL SYSTEMS	FINANCIAL SYSTEMS	DEPARTMENTAL	GENERAL ACCESS
<input type="checkbox"/> Cerner CWX <input type="checkbox"/> PowerChart <input type="checkbox"/> Ambulatory <input type="checkbox"/> FirstNet <input type="checkbox"/> PathNet <input type="checkbox"/> RadNet <input type="checkbox"/> Surgery <input type="checkbox"/> PharmD <input type="checkbox"/> BioRad Unity <input type="checkbox"/> Omnicell <input type="checkbox"/> Omnicell (M.M.) <input type="checkbox"/> Med Carts <input type="checkbox"/> eCW <input type="checkbox"/> AGFA-Impax <input type="checkbox"/> Affinity	<input type="checkbox"/> Revenue Cycle <input type="checkbox"/> Medhost <input type="checkbox"/> Parexcellence <input type="checkbox"/> EDM Financials <input type="checkbox"/> Supply Chain <input type="checkbox"/> Budease	<input type="checkbox"/> HIM Access <input type="checkbox"/> EDM-HIM <input type="checkbox"/> EDM Clinician Access <input type="checkbox"/> Bedrock <input type="checkbox"/> DA2 <input type="checkbox"/> Lighthouse <input type="checkbox"/> Lights On <input type="checkbox"/> Management <input type="checkbox"/> User Maint. Tool <input type="checkbox"/> Ram Soft <input type="checkbox"/> Appt. Scheduling <input type="checkbox"/> CDI Work Queue <input type="checkbox"/> 3M Coding <input type="checkbox"/> Aperek <input type="checkbox"/> eCare Next <input type="checkbox"/> Midas	<input type="checkbox"/> Email <input type="checkbox"/> Remote Access <input type="checkbox"/> SharePoint <input type="checkbox"/> Network Shares <input type="checkbox"/> UKG & Navex <input type="checkbox"/> TigerText <input type="checkbox"/> Tiger Connect <input type="checkbox"/> Bullhorn <input type="checkbox"/> Long Distance Code <input type="checkbox"/> Documents <input type="checkbox"/> Green Security <input type="checkbox"/> CBORD <input type="checkbox"/> Provider Dictation <input type="checkbox"/> Impax

Other Applications / Folders / Special Access: \_\_\_\_\_

**3. REQUIRED SIGNATURES**

By signing this form, the manager/director accepts responsibility for and acknowledges that this employee has read and understands all rules and regulations related to IVHD's policies and procedures, including policies related to employee passwords, usernames, computer and internet use. All security policies are available in Navex. All information on this security sheet must be completed in its entirety and submitted by the manager or director. Human Resources will process and activate the employee in the required IVHD systems. Processing and activation may take up to three (3) business days. Once activated, the employee will receive their network (email) login information from HR. All application usernames and passwords will be sent to their IVHD email. It is the employee's responsibility to check their email at the beginning of their first shift.

Supervisor Signature: _____ Supervisor Printed Name: (Medical Staff Services Staff)  EID#: _____	Date: _____
HR Signature: _____  EID#: _____	Date: _____

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT  
**SECURITY ACCESS WORKSHEET- CONTINUED**  
*(Supplement 4, Pg 2)*

IDENTIFYING INFORMATION		
Last Name: <b>«LastName»</b>	First: <b>«FirstName»</b>	Middle: <b>«MiddleName»</b>

**4. SECURITY AND PROCESS ACKNOWLEDGEMENT**

I certify that the above information is correct. By signing, I agree to abide by the standards of the Health Insurance Portability and Accountability Act (HIPAA) and other Protected Health Information (PHI) standards (CMS/DHS). I acknowledge and agree to the following requirements:

1. I will act in the best interest of Imperial Valley Healthcare District and in accordance with its policies, procedures and security standards at all times during my relationship with IVHD.
2. I understand that I should have a reasonable expectation of privacy when using IVHD information systems. IVHD may access, review, and otherwise utilize information stored on or passing through its systems in order to manage system access and enforce security.
3. I understand that I have no right to any ownership interest in any information, data, or other materials accessed or created by me during my relationship with IVHD.
4. I will not share any password given to me by IVHD. I further understand that security passwords are highly confidential and must not be shared with others. I will take reasonable precautions to safeguard my passwords. If I suspect that my password has been compromised (observed or learned by another person), I will immediately notify Information Systems at 760.482.5300 so that a new password can be issued. I will change my security password on a periodic basis as directed, at least every 60 days.
5. I AGREE NO HOSPITAL INFORMATION, PHI OR OTHERWISE, WILL BE DOWNLOADED TO MY PERSONAL DEVICES. I will only use my officially assigned user ID, password, and authorized devices.
6. I will use devices with virus protection software. I will report theft or loss of devices that store Confidential Information within 24 hours.
7. I will never share or disclose user IDs or passwords, nor will I ask others to do so. I will not use tools or techniques to break or exploit security measures. I will not connect to unauthorized networks through IVHD systems or devices.
8. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not put it in any way, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
9. I will not make unauthorized transmissions, inquiries, modifications, or purging of Confidential Information. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
10. I will only access information systems to review patient records for which my job responsibilities have a legitimate need to access for treatment or healthcare operations.
11. I will notify my Information Services or House Supervisor if my password has been seen, disclosed or otherwise compromised, and will promptly report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
12. I will abide by the minimum security standards for network devices set forth in IVHD policies and procedures.
13. Upon termination of my relationship with IVHD, I will immediately return any documents or media containing Confidential Information to IVHD.
14. I understand that violation of this Agreement may result in termination or authorization to access confidential information at IVHD.

**Additional Requirements for Physicians and Contracted Entities:**

15. I will insure that only appropriate personnel in my office will access IVHD electronic systems and I will annually train such personnel on issues related to patient confidentiality and access.
16. I will accept full responsibility for the actions of my employees who may access IVHD electronic systems and Confidential Information.

**I ACKNOWLEDGE THAT I HAVE READ THIS AGREEMENT AND I AGREE TO COMPLY WITH THE TERMS AND CONDITIONS STATED ABOVE.**

<b>Employee/Physician Signature:</b>	<b>Date:</b>
--------------------------------------	--------------

**5. ADDITIONAL INFORMATION FOR MEDICAL STAFF and CONTRACTED ENTITIES**

*This section applies to physicians and contracted entities using IVHD systems containing patient identifiable health information.*

<b>Role:</b> <input type="checkbox"/> Physician <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Other:
<b>Contact Information:</b> Phone: _____ Email: _____

**Reference Information:** Policies can be found online at: HIPAA: <https://www.hhs.gov/hipaa/for-professionals/index.html>

DHS: <http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/Medicaidstatute.aspx>

CMS: <https://www.cms.gov/regulations-and-guidance/administrative-simplification/hipaa-aca/privacyandsecurityinformation>

**FOR INTERNAL USE ONLY - Information Systems Department**

<input type="checkbox"/> Remote Access	<input type="checkbox"/> Email	<input type="checkbox"/> Tiger Connect	<input type="checkbox"/> Provider Dictation	<input type="checkbox"/> Impax
<input type="checkbox"/> Cerner CWX	<input type="checkbox"/> Provider Role	<input type="checkbox"/> EDM Clinician	<input type="checkbox"/> Other:	

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**  
**INFLUENZA VACCINATION FORM**  
**Supplement 5**  
*\*Return this page with your application\**

IDENTIFYING INFORMATION		
Last Name: <b>«LastName»</b>	First: <b>«FirstName»</b>	Middle: <b>«MiddleName»</b>

**PLEASE COMPLETE THE ONE (1) SECTION BELOW THAT APPLIES TO YOU**

**SECTION 1**

I want to receive the Influenza Vaccine. Contact Employee Health Nurse at 760-339-7199 (El Centro) or 760-351-3309, (Pioneers), for appointment/information. (Available September to March)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

**SECTION 2**

Received Influenza Vaccine Received elsewhere. Attach documentation verifying vaccination.

Location (Name of hospital, clinic, etc): \_\_\_\_\_

Date of Vaccination: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

---

**SECTION 3**

I choose to DECLINE vaccination at this time.

**NOTE:** Hospital policy, adopted by the Medical Staff, states that any healthcare worker who declines vaccination is required to wear a mask when delivering direct patient care. This is effective during the "Influenza Season".

I decline vaccination for the following reason(s):

***Please check all that apply:***

- I believe I will get the flu if I receive the vaccination
- I do not like needles
- My philosophical or religious beliefs prohibit vaccination
- I have a medical contraindication to receiving the vaccine
- I do not wish to say why I decline
- Other Reason: \_\_\_\_\_

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
*CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT*  
**MEDICARE ACKNOWLEDGEMENT STATEMENT**

**Supplement 6**

*\*Please return this page with your application\**

IDENTIFYING INFORMATION		
Last Name: «LastName»	First: «FirstName»	Middle Initial: «MiddleName»

*\*Return this page with your application\**

**NOTICE TO PHYSICIANS**

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record.

Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds, may be subject to fine, imprisonment, or civil penalty under applicable federal laws.

APPLICANT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT  
**Physician Preference/Alternate Coverage**  
**Supplement 7**  
*\*Return this page with your application\**

IDENTIFYING INFORMATION		
Last Name: «LastName»	First: «FirstName»	Middle Initial: «MiddleName»

**PHYSICIAN PREFERENCE**  
**COMPLETE SECTIONS A-D BELOW**

A. OFFICE INFORMATION			
OFFICE ADDRESS	«Office1Address», «Office1AddressCity», «Office1AddressState», «HomeAddressZip»		
OFFICE PHONE	«Office1AddressTelephone»	FAX	«PrimaryAddressFax»
CELL PHONE	«CellPhone»	EMAIL	«Email»
OFFICE MANAGER NAME		PHONE	EMAIL

B. REFERRED CONTACT INFORMATION	
<b>DURING OFFICE HOURS:</b> 8:00AM – 5:00PM, Monday- Friday - Contact Method (i.e., cell, office, email, tigertext, etc)	
FIRST CONTACT NUMBER	
SECOND CONTACT NUMBER	
THIRD CONTACT NUMBER	

C. REFERRED CONTACT INFORMATION	
<b>AFTER OFFICE HOURS:</b> Weekends, Holidays - Contact Method (i.e., cell, office, email, tigertext, etc)	
FIRST CONTACT NUMBER	
SECOND CONTACT NUMBER	
THIRD CONTACT NUMBER	

ALTERNATE COVERAGE	
<ul style="list-style-type: none"> <li>Alternate must be a member of the Medical Staff of the Imperial Valley Healthcare District, same campus, and has either the same, or comparable privileges.</li> <li>Alternate must agree to be called for your patients, when you are out of town or if the hospital is unable to reach you.</li> <li>You will inform the Medical Staff Services Office in writing if you should change this designation at any time.</li> </ul>	
<b>I ATTEST that the practitioner noted below has AGREED to be my ALTERNATE when I am out of town or if the hospital is unable to reach me:</b>	
I, «FormalNameWithDegree» _____ have communicated with, and confirmed this matter with _____ <div style="text-align: right; font-size: small;">(PRINT NAME OF ALTERNATE)</div>	
LIST ALTERNATE'S OFFICE PHONE	
LIST ALTERNATE'S CELL PHONE	
OTHER CONTACT INFORMATION	

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(THIS SECTION COMPLETED BY STAFF)

ALTERNATE CONFIRMED BY MSO STAFF, SIGNATURE/DATE: _____	METHOD: <input type="checkbox"/> EMAIL <input type="checkbox"/> TIGERTEXT <input type="checkbox"/> OTHER, (SPECIFY) _____ DOCUMENTATION IS PLACED IN CREDENTIAL FILE.
--	--

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**  
**PROVIDER SIGNATURE FORM**  
**Supplement 8**  
*\*Return this page with your application\**

IDENTIFYING INFORMATION		
Last Name: «LastName»	First: «FirstName»	Middle Initial: «MiddleName»

When real-time hand written signatures are utilized in the hospital, the Pharmacy and Health Information Management departments are required to maintain a mechanism of identifying the signatures of practitioners.

**Since no signatures are identical, please provide two (2) sample signatures for identification:**

Sample (1): \_\_\_\_\_

Sample (2): \_\_\_\_\_

STAFF TO SEND COPY TO: PHARMACY, HIM

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT  
**TUBERCULOSIS SCREENING**  
**Supplement 9**  
*\*Return this page with your application\**

DATE	
NAME	«LastName», «FirstName», «MiddleName»
DATE OF BIRTH	«BirthDate»
CONTACT PHONE #	«OFFICE1AddressTelephone»

**REQUIRED TUBERCULOSIS SCREENING DOCUMENTATION TO BE SUBMITTED**

Negative TB Quantiferon screening within 12 months prior to start date, consisting of the following:

- Proof of NEGATIVE Quantiferon AND completed Signs and Symptoms Questionnaire (below)
- If POSITIVE Quantiferon, proof of chest x-ray AND completed Signs and Symptoms Questionnaire (below)

**Note: Documentation must include your name, date of testing, institution name and address, phone number. If submitting proof of chest x-ray, must include report.**

**SIGNS AND SYMPTOMS QUESTIONNAIRE**

Since your last TB screening have you, experienced any of the following symptoms for more than three (3) weeks?

*(Please circle the correct answer)*

Symptoms	YES	NO
Persistent Fever	YES	NO
Night sweats	YES	NO
Unplanned/Unexplained weight loss	YES	NO
Loss of appetite	YES	NO
Persistent cough	YES	NO
Excessive fatigue	YES	NO

APPLICANT SIGNATURE:	DATE:
----------------------	-------

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
**CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT**  
**CURRENT ACTIVITY REQUEST**  
**Supplement 10**  
*\*Return this page with your application\**

**ATTN:** MEDICAL STAFF SERVICES and/or HEALTH INFORMATION MANAGEMENT

**SUBJECT:** REQUEST FOR ACTIVITY  
REGARDING PHYSICIAN/DOB \_\_\_\_\_

PRINT YOUR NAME / DATE OF BIRTH

To Whom It May Concern:

I am currently in the appointment or reappointment process for Medical Staff Membership and Clinical Privileges at **Imperial Valley Healthcare District, El Centro and/or Pioneers Hospital campus.**

As such, please forward any reports which reflect my overall activity at your facility. I ask that this include any procedures performed at your facility within the past 24 months.

By submission of this request, I hereby consent to release of appropriate information concerning my medical practice. I waive any cause of action activity of the **Imperial Valley Healthcare District**, members of the Medical Staff, or governing board, as a result of their review or discussion of my present or past medical performance, in considering my request for medical staff membership and clinical privileges at **Imperial Valley Healthcare District, El Centro and/or Pioneers Hospital campus.**

Please forward the requested information to Medical Staff Services office:

Pioneers: [schava@IV-hd.org](mailto:schava@IV-hd.org) or Fax: 760-352-4546 |  El Centro: [medical-staff-support@ecrmc.org](mailto:medical-staff-support@ecrmc.org) or Fax: 760-339-9904

Thank you for your time and attention to this matter.

APPLICANT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

*(Applicant: This form is to expedite a clinical activity report that will be requested from your current and past hospital affiliations. If you have any questions, please contact the medical staff services office.)*

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
*CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT*  
**EDUCATION MODULE ACKNOWLEDGEMENT**

**Supplement 11**

*\*Return this page with your application\**

**THIS PAGE REMAINS UNDER REVIEW AND UPDATE**

**IDENTIFYING INFORMATION**

Last Name: **«LastName»**

First: **«FirstName»**

Middle Initial: **«MiddleName»**

My signature below indicates that I have received and had the opportunity to review the Medical Staff Educational modules as noted below:

- 1) Guidelines for Oral Anticoagulation – With Enoxaparin (Lovenox)
- 2) Safety Alert-Dilaudid\_Hydromorphone for Injection
- 3) NIH Guidelines for Therapeutic Management of Non-Hospitalized Adults with COVID-19
- 4) Antimicrobial Medications Listing
- 5) Emergency Management – Disaster Plan Activation/ Disaster Privileges
- 6) Physician Health – Impairment Recognition, Issues Specific to LIPs
- 7) Standards of Conduct
- 8) Workplace Violence Prevention
- 9) Fall Reduction & Prevention – Assessment, Intervention
- 10) Restraints
- 11) Information Management – Downtime Procedures
- 12) Compliance & Diversity
- 13) Safety Essentials – Review of Codes, Fire Safety, Spill Safety

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
*CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT*  
**ELECTRONIC PRESCRIPTIONS CONTROLLED SUBSTANCES**  
(EPCS ePrescribing)

**Supplement 12**

*\*Return this page with your application\**

IDENTIFYING INFORMATION		
Last Name: «LastName»	First: «FirstName»	Middle Initial: «MiddleName»

**EPCS ePrescribing**

ePrescribing (eScripting) of controlled substances provides the ability for prescribers to electronically transmit controlled substance prescriptions to outpatient mail or retail pharmacies. The regulations will also permit pharmacies to receive, dispense, and archive these electronic prescriptions. The new regulations, mandate that practitioners prescribe controlled substances using only electronic prescriptions.

Benefits of ePrescribing include a reduction in prescription errors caused by illegible hand writing, automated drug interaction and allergy checking, improvement in patient safety and increased efficiency through alerts and decision support. Benefits of EPCS include minimizing diversion of prescriptions, abuse of controlled substances, lost or stolen prescription pads or scripts, altered scripts and fraudulent use of DEA numbers.

My signature below signifies my understanding of this process and my request to utilize the EPCS ePrescribing system at Imperial Valley Healthcare District:

**Pioneers Campus**     **El Centro Campus**     **Both Campuses**

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Imperial Valley Healthcare District  
**MEDICAL STAFF APPLICATION**  
CONFIDENTIAL AND PROTECTED MEDICAL STAFF DOCUMENT

*\*This page is for your perusal and reference, please do not return\**

**IMPORTANT EXCERPTS  
MEDICAL STAFF BYLAWS**

<b>Subject</b>	<b>Article</b>
Appointment, Reappointment	Article V
Active Status requirements	Article III, 3.2
Initial FPPE Proctoring	Article III, 3.5-3, 4, 5 Article V, 5.3 Article VI, 6.2-2
FPPE for Cause	Article 6.2-3
Evaluation and Corrective Action; Peer Review, Ongoing Peer Review; Peer Review Criteria	Article VI, 6.1, 6.2, 6.2-1
OPPE	Article 6.2-4, 5
Automatic Suspension (Includes Medical Record Suspension)	Article 6.5



**TO:** ECRMC BOARD MEMBERS

**FROM:** Andrew LaFree, M.D., Chief of Staff

**DATE:** March 23, 2026

**MEETING:** Board of Trustees

**SUBJECT:** **MEDICAL STAFF OPPE FREQUENCY CHANGE**

**BUDGET IMPACT:**  Does not Apply  
 Yes  No

A. Does the action impact/affect financial resources?

B. If yes, what is the impact amount: \_\_\_\_\_

**BACKGROUND:** The current Ongoing Professional Performance Evaluation (OPPE) process is conducted at nine (9)-month intervals. Upon review of applicable accreditation standards and regulatory requirements, it is recommended that the OPPE review cycle be revised to occur at every twelve (12) months. This proposed modification aligns the organization’s OPPE process with prevailing accreditation guidelines and regulatory expectations, while maintaining the Medical Staff’s responsibility for ongoing monitoring of practitioner competence and professional performance. Transitioning to a twelve (12)-month review cycle will continue to support effective performance oversight, ensure compliance, and promote consistency within the credentialing and privileging framework. This recommendation is hereby submitted to the Board of Trustees for final review, consideration, and approval.

**DISCUSSION:** The purpose of the Ongoing Professional Performance Evaluation (OPPE) is to provide a continuous, systematic, and objective process for monitoring and evaluating the clinical competence and professional performance of practitioners who have been granted Medical Staff membership and clinical privileges. OPPE supports the Medical Staff’s responsibility for quality oversight and aligns with applicable accreditation standards and regulatory requirements. The process is designed to ensure that practitioners consistently deliver safe, effective, and high-quality patient care in accordance with established standards of practice. OPPE incorporates both qualitative and quantitative performance data. This ongoing assessment enables the early identification of trends, variations in performance, or opportunities for improvement. The OPPE process serves to inform leaders in decisions related to the continuation, modification, or limitation of clinical privileges at the time of reappointment. Overall, OPPE promotes accountability, supports continuous professional development, enhances patient safety, and ensures that the Medical Staff maintains a high standard of clinical excellence.

**RECOMMENDATION:** (1) Approve (2) Do not approve

**ATTACHMENT(S):** NONE.

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo Velazquez



**TO:** HOSPITAL BOARD MEMBERS  
**FROM:** David Momberg, Chief Financial Officer  
**DATE:** March 23, 2026  
**MEETING:** Board of Trustees

**SUBJECT:** Feb 2026 Month and Year-to-Date Financial Statements

**BUDGET IMPACT:**  Does not Apply  
A. Does the action impact/affect financial resources?  Yes  No  
B. If yes, what is the impact amount: \_\_\_\_\_

**BACKGROUND:** The month of February resulted in net operating loss of \$1.4M, a negative margin of 12% and positive EBIDA of \$322K. FYTD EBIDA is positive at \$4.3M and positive margin YTD of 4.3%.

**DISCUSSION:** For a more detailed description of financial performance, please see the attached Financial Report.

**RECOMMENDATION:** (1) Approve (2) Do not approve

**ATTACHMENT(S):**

- Financial Packet for February 2026

Approved for agenda, Chief Executive Officer

Date and Signature: \_\_\_\_\_

*Pablo Velazquez*



## February 2026 Financial Report

March 23, 2026

**To: Finance Committee**

**From: David Momberg, Chief Financial Officer**

The following package contains:

- Comparative volumes vs. Prior Month/Year
- Balance Sheet vs. Prior Month comparison
- Operating Statement vs. Prior Month comparison
- Monthly Cash Flow (Fiscal Year to Date)

### **Balance Sheet:**

- a) Cash and Cash Equivalents increased (\$1.6M) due to UBS funds pulled partially offset by IGT sent for DHDP/QIP programs.
- b) Other receivables decreased (\$55k) due to 340b pharmacy payments received mainly Optum.
- c) Due from Third-Party payors increased (\$7.1M) due to IGT sent for DHDP/QIP programs coupled with other supplemental programs pending to receive.
- d) Deferred Outflows of Resources – Pension decreased (\$711k) due to lower pension payments made during the month related to credit account.
- e) Accounts Payable and Accrued Expenses increased (\$2.7M) mainly due to large ETC invoice entered, coupled with invoices entered not paid during the period.
- f) Net Pension Liability increased (\$8M) due to funds moved from UBS.
- g) Days in A/R decreased to 71.8 from 74.56. The goal is 50 days.

- h) Accounts payable days decreased, 80.92 vs. 84.93 days from previous month.
- i) Current Ratio is 1.81 (1.77 last month).

**Income Statement – Current Month Actual vs. Prior Month:**

- a) Our Inpatient Revenue was 10.6% lower due to lower patient days (1,393 vs. 1,538 prior month).
- b) Our Outpatient Revenue was 3.2% lower mainly due to lower laboratory and radiology revenues.
- c) Other Operating Revenue was 30.1% higher due to physician billing posted in the month.
- d) Contractuals for the month were 82.1% of gross revenues (82.1% YTD). Contractuals for January were affected by Cerner mas adjustments.
- e) Charity and Bad debt were 1.7% of gross revenues.
- f) Registry was 80.7% lower due to lower pharmacy registry expenses.
- g) Employee benefits was 13.1% higher due to Workers Compensation accrual adjustment.
- h) Professional Fees – Non-Medical was 17% higher mainly related to Lorraine Tong attorney fees.
- i) Supplies Medical was 23.4% higher mainly due to higher infusion therapy procedures performed during the month.
- j) Supplies Non-medical was 13% lower due to supplies in Nutrition services department.
- k) Repairs and Maintenance was 19.4% higher due to Healthcare Financial Services expense catch-up (new PET/CT trailer).
- l) Lease and Rental returned back to normal after MedOne pumps expense release.
- m) Other Fees was 25.1% lower due to Softscript settlement invoices cancelled previous month.
- n) Other Expenses was 27.4% lower due to Softscript settlement payment made in January 2026.
- o) February 2026 shows a Net loss of \$1.4M (\$323k positive EBIDA).

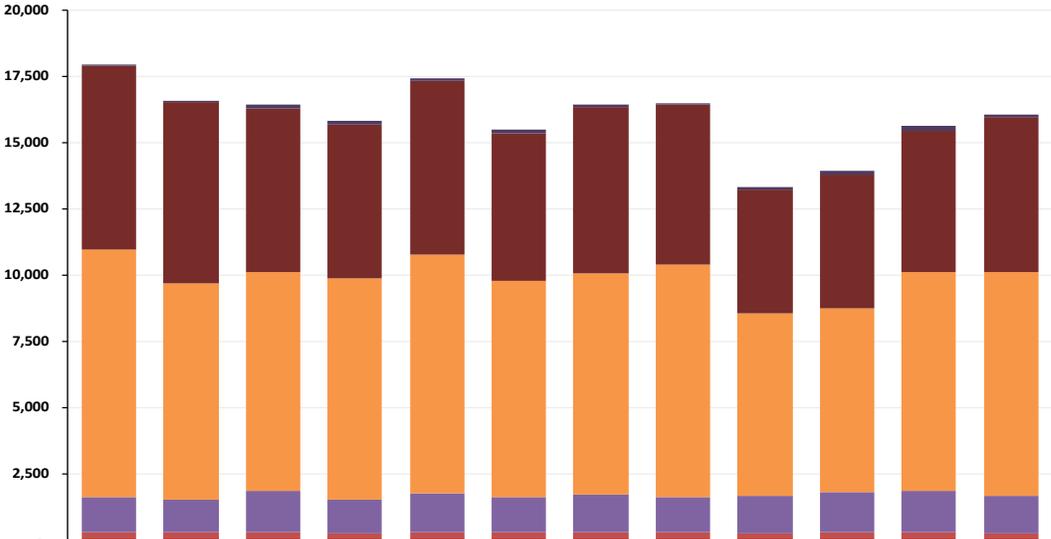
**Definitions:**

- **EBIDA** - Earnings Before Interest, Depreciation, and Amortization.
- **Contribution Margin** – Total Revenue minus Expenses (excluding functional areas of IT, Finance, HR, and management assessments/restructuring costs).
- **EBIDA Margin** – EBIDA/Total Revenue.
- **Operating Expenses Per Day** – Total Expenses less Depreciation divided by Days.
- **Operating Revenue Per Day** – Operating Income/Days.
- **Days Cash on Hand** – Cash/Operating Expenses per Day.
- **Days Revenue in A/R** – Accounts Receivable/Operating Revenue per Day.
- **Current Ratio** – Current Assets/Current Liabilities.
- **Equity Financing Ratio** – Total Capital/Total Debt.

**EI Centro Regional Medical Center  
Comparative Volumes as of February 28, 2026**

	Nov 2025	Dec 2025	Jan 2026	Feb 2026	YTD Actual	YTD Budget	YTD Variance
Adult Admissions (excl. Observation)	275	318	316	257	2,330	2,139	191
Patient Days (excl. Observation)	1,371	1,510	1,538	1,393	11,372	10,693	679
Average Length of Stay (excl. Observation)	5.0	4.7	4.9	5.4	4.9	5.0	(0.1)
Average Daily Census (excl. Observation)	45.7	48.7	49.6	49.8	46.8	46.4	0.4
Average Daily Census (ADC) Observation	3.7	4.5	5.1	3.6	3.7	5.1	(1.4)
Total ADC (including Observation)	49.4	53.2	54.7	53.4	50.5	51.5	(1.0)
Observation Days (excluding Obstetrics)	110	140	158	101	907	1,104	(197)
Outpatient Visits (excluding Clinics)	6,912	6,931	8,276	8,487	64,871	61,024	3,847
Emergency Room Visits	2,765	3,052	3,211	3,001	23,416	22,596	820
EI Centro Rural Health Clinic Visits	2,310	2,585	2,576	2,863	22,960	27,398	(4,438)
Calexico Rural Health Clinic Visits	1,708	1,826	2,065	2,250	17,037	21,638	(4,601)
Rural Health Clinic Visits - Total	4,018	4,411	4,641	5,113	39,997	49,036	(9,039)
Wound Healing Center Visits	127	133	143	135	1,089	1,144	(55)
Oncology Center Visits	532	482	557	576	4,267	4,974	(707)
Oncology Center Infusion Procedures	1,202	1,411	1,300	1,350	10,506	11,102	(596)
Surgeries without C-Sections	421	371	432	432	3,527	3,438	89
DaVinci Cases	55	49	31	49	301	414	(113)

### Rolling-12 Volume Trend



	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025	Jan 2026	Feb 2026
■ Observation Days	84	69	111	110	100	124	89	85	110	140	158	101
■ Total Clinic Visits (RHCs, ONC, WHC)	6,899	6,836	6,203	5,820	6,556	5,596	6,291	6,042	4,677	5,026	5,341	5,824
■ Outpatient Visits (excl. Clinics)	9,341	8,165	8,238	8,357	9,017	8,164	8,352	8,732	6,912	6,931	8,276	8,487
■ Adult Patient Days (excl. Observation)	1,344	1,241	1,563	1,260	1,466	1,334	1,417	1,343	1,371	1,510	1,538	1,393
■ Adult Admissions	298	289	302	256	292	279	292	301	275	318	316	257

## ECRMC BALANCE SHEET COMPARED TO PRIOR MONTH

	February 28, 2026	January 31, 2026	Variance (\$)	Variance (%)
<b>Assets</b>				
Current Assets:				
Cash and Cash Equivalents	\$ 3,284,381	\$ 1,731,999	\$ 1,552,382	90%
Net Patient Accounts Receivable	21,731,915	22,117,746	(385,832)	-2%
Other Receivables	187,645	242,778	(55,134)	-23%
Due from Third-Party Payors	58,071,658	50,960,519	7,111,139	14%
Inventories	2,951,771	2,953,018	(1,247)	0%
Prepaid Expenses & Other	1,461,102	1,570,017	(108,915)	-7%
<b>Total Current Assets</b>	<b>87,688,471</b>	<b>79,576,078</b>	<b>8,112,394</b>	<b>10%</b>
Assets Limited as to Use				
Restricted Building Capital Fund	342,779	335,821	6,957	2%
Funds Held by Trustee for Debt Service	11,340,708	10,678,644	662,064	6%
Restricted Programs	11,497	11,497	-	0%
<b>Total Assets Limited as to Use</b>	<b>11,694,984</b>	<b>11,025,962</b>	<b>669,022</b>	<b>6%</b>
Property, Plant, and Equipment: Net	157,523,260	156,615,530	907,729	1%
Other Assets	1,149,028	1,076,862	72,166	7%
<b>Total Assets</b>	<b>258,055,743</b>	<b>248,294,432</b>	<b>9,761,310</b>	<b>4%</b>
<b>Deferred Outflows of Resources</b>				
Deferred Outflows of Resources - Pension	(2,877,953)	(2,167,671)	(710,282)	33%
<b>Total Deferred Outflows of Resources</b>	<b>(2,877,953)</b>	<b>(2,167,671)</b>	<b>(710,282)</b>	<b>33%</b>
<b>Total Assets and Deferred Outflows of Resources</b>	<b>\$ 255,177,790</b>	<b>\$ 246,126,762</b>	<b>\$ 9,051,028</b>	<b>4%</b>
<b>Liabilities</b>				
Current Liabilities:				
Current Portion of Bonds	1,445,000	1,440,000	5,000	0%
Current Portion of Capital Lease Obligations	865,255	878,178	(12,924)	-1%
Accounts Payable and Accrued Expenses	27,292,912	24,580,036	2,712,876	11%
Accrued Compensation and Benefits	8,972,948	8,879,564	93,384	1%
Due to Third-Party Payors	9,754,692	9,236,173	518,519	6%
<b>Total Current Liabilities</b>	<b>48,330,807</b>	<b>45,013,951</b>	<b>3,316,855</b>	<b>7%</b>
Long-Term Bond Payable, Less Current Portion	110,970,866	111,072,133	(101,267)	0%
Capital Lease Obligations, Less Current Portion	3,701,962	3,900,232	(198,270)	-5%
Notes Payable, Less Current Portion	23,851,852	24,370,370	(518,519)	-2%
Net Pension Liability	60,851,200	52,851,200	8,000,000	15%
<b>Total Liabilities</b>	<b>247,706,687</b>	<b>237,207,887</b>	<b>10,498,800</b>	<b>4%</b>
<b>Deferred Inflows of Resources</b>				
Deferred Inflows of Resources - Pension	-	-	-	0%
<b>Total Deferred Inflows of Resources</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>0%</b>
<b>Net Position</b>				
Restricted Fund Balance	27,465	27,366	99	0%
Fund Balance	7,443,638	8,891,508	(1,447,870)	-16%
<b>Total Net Position</b>	<b>7,471,104</b>	<b>8,918,875</b>	<b>(1,447,771)</b>	<b>-16%</b>
<b>Total Liabilities, Deferred Inflows of Resources and Net Position</b>	<b>\$ 255,177,790</b>	<b>\$ 246,126,762</b>	<b>\$ 9,051,028</b>	<b>4%</b>
Days Cash on Hand	8.78	4.78		
Days Revenue in A/R	71.80	74.56		
Days in A/P	80.92	84.93		
Current Ratio	1.81	1.77		
Debt Service Coverage Ratio	3.73	3.67		

# STATEMENTS OF OPERATIONS

	MTD November 30, 2025	MTD December 31, 2025	MTD January 31, 2026	MTD February 28, 2026	YTD February 28, 2025	YTD February 28, 2026	YTD BUDGET February 28, 2026
Adult Admissions	275	318	316	257	2,087	2,330	2,139
Adult Patient Days (excl. Observation)	1,371	1,510	1,538	1,393	10,781	11,372	10,693
Outpatient Visits (excl. Clinics)	6,912	6,931	8,276	8,487	58,774	64,871	61,024
Total Clinic Visits (RHCs, ONC, WHC)	4,677	5,026	5,341	5,824	55,208	45,353	55,154
Observation Days	110	140	158	101	1,227	907	1,104
<b>OPERATING REVENUE</b>							
I/P Revenue	\$ 15,738,608	\$ 16,419,418	\$ 15,950,081	\$ 14,264,602	\$ 123,746,027	\$ 124,366,231	\$ 126,019,004
O/P Revenue - Laboratory	5,581,064	5,879,473	7,146,719	6,516,518	48,317,488	50,062,711	46,724,959
O/P Revenue - CT Scanner	6,039,224	6,345,163	6,337,543	4,222,748	49,057,814	47,748,597	88,593,112
O/P Revenue - Emergency Room	7,053,181	7,458,801	7,452,967	8,126,341	52,532,050	57,742,727	51,281,007
O/P Revenue - Oncology	735,114	730,954	787,639	672,433	31,201,548	5,531,805	25,923,081
O/P Revenue - Others	21,501,656	22,436,299	21,784,153	22,565,001	155,604,372	180,131,445	193,728,242
Gross Patient Revenues	56,648,847	59,270,108	59,459,102	56,367,644	460,459,298	465,583,515	532,269,405
Other Operating Revenue	(1,227,436)	332,045	432,495	304,673	2,884,735	2,681,966	3,384,967
Total Operating Revenue	55,421,410	59,602,153	59,891,598	56,672,317	463,344,033	468,265,481	535,654,372
Contractuals							
IP Contractuals	9,124,296	11,312,704	13,565,507	11,115,898	93,829,431	92,371,181	95,821,872
OP Contractuals	36,338,944	36,708,622	35,420,392	35,153,942	268,727,536	290,042,718	336,166,763
Charity	53,588	47,125	112,781	126,734	1,138,540	667,988	1,162,412
Provision for Bad Debts	620,158	693,460	649,271	857,352	4,392,910	5,448,391	4,555,010
Other Third Party Programs	(2,474,250)	(2,474,250)	(2,474,250)	(2,474,250)	(12,112,778)	(19,959,565)	(11,939,022)
M/Cal Disproportionate Share	0	0	0	0	(440,000)	0	(352,000)
Total Deductions	43,662,737	46,287,661	47,273,701	44,779,675	355,535,640	368,570,714	425,415,036
Total Net Revenues	11,758,673	13,314,492	12,617,897	11,892,641	107,808,393	99,694,767	110,239,336
<b>EXPENSES</b>							
Salaries & Wages	5,095,830	5,126,388	5,335,180	4,743,734	41,214,248	41,292,098	42,366,217
Registry	104,212	50,746	33,813	6,536	177,271	798,937	219,181
Employee Benefits	469,764	937,717	571,881	646,928	7,269,157	6,140,337	7,415,197
Employee Benefits - Pension GASB 68	719,600	719,600	719,600	710,282	4,726,832	5,728,553	4,925,185
Professional Fees - Medical	1,365,126	1,293,415	1,273,852	1,308,173	9,890,916	10,602,278	12,024,738
Professional Fees - Non-Med	115,107	371,960	171,622	418,503	1,733,889	1,930,862	1,685,367
Supplies - Medical	2,413,458	2,610,913	2,000,484	2,467,833	19,445,879	19,890,106	19,543,742
Supplies - Non-Medical	153,765	162,957	136,673	118,853	1,126,425	1,128,624	1,283,228
Food	83,978	83,409	89,939	87,301	642,502	698,808	638,918
Repairs and Maintenance	634,608	538,141	560,375	669,025	5,579,117	4,945,792	5,483,231
Other Fees	630,726	496,173	453,854	567,897	4,486,729	4,268,129	5,077,156
Lease and Rental	28,756	33,782	24,944	31,431	207,329	224,988	232,196
Utilities	190,528	180,694	189,335	188,757	1,624,983	1,459,476	1,577,079
Depreciation and Amortization	227,580	543,389	544,312	472,945	4,807,681	4,039,559	4,858,200
Insurance	169,807	174,273	169,807	179,202	1,535,543	1,446,074	1,466,106
Other Expenses	104,884	116,241	227,497	165,094	897,671	1,083,025	899,362
Total Operating Expenses	12,507,728	13,439,797	12,503,168	12,782,492	105,366,172	105,677,646	109,695,102
Operating Income	(749,055)	(125,305)	114,729	(889,851)	2,442,221	(5,982,879)	544,234
Operating Margin %	-6.4%	-0.9%	0.9%	-7.5%	2.3%	-6.0%	0.5%
Non-Operating Revenue and Expenses							
Investment Income	39,040	25,870	163,111	29,498	474,472	545,874	456,611
Grants and Contributions Revenue	0	0	0	0	63,120	0	850,496
Non Operating Revenue/(Expense)	0	0	0	0	661,875	0	529,500
Interest Expense	(585,092)	(584,909)	(585,800)	(587,518)	(4,750,958)	(4,691,339)	(4,758,466)
Total Non-Operating Rev. and Expenses	(546,052)	(559,040)	(422,689)	(558,020)	(3,551,490)	(4,145,465)	(2,921,859)
(Deficit)/Excess Rev. Over Exp.	\$ (1,295,107)	\$ (684,345)	\$ (307,960)	\$ (1,447,870)	\$ (1,109,269)	\$ (10,128,344)	\$ (2,377,624)
(Deficit)/Excess Rev. Over Exp. %	-11.0%	-5.1%	-2.4%	-12.2%	-1.0%	-10.2%	-2.2%
EBIDA	237,165	1,163,553	1,541,752	322,875	13,176,201	4,331,106	12,164,226
EBIDA %	2.0%	8.7%	12.2%	2.7%	12.2%	4.3%	11.0%

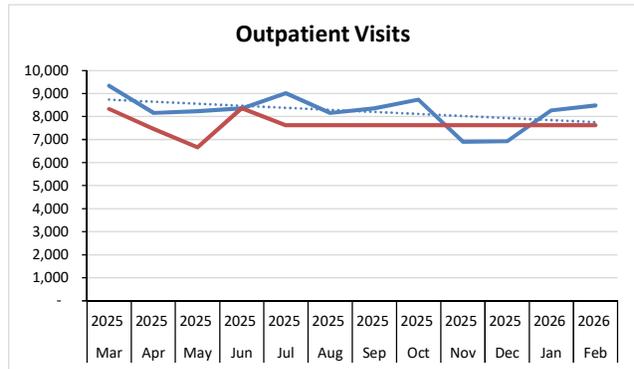
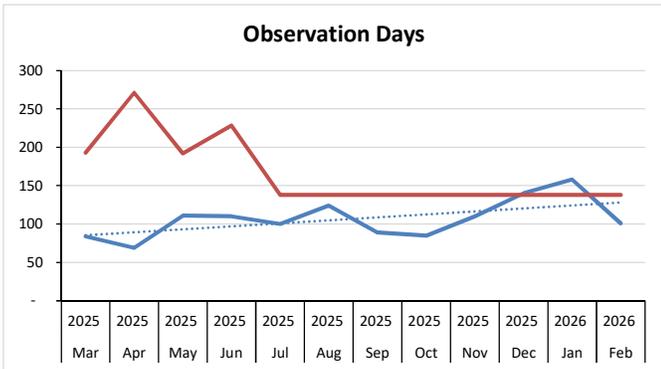
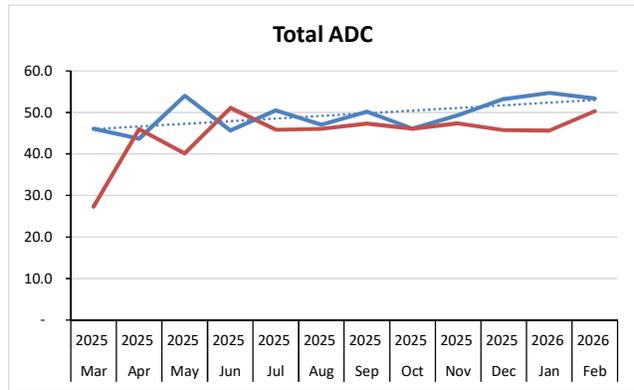
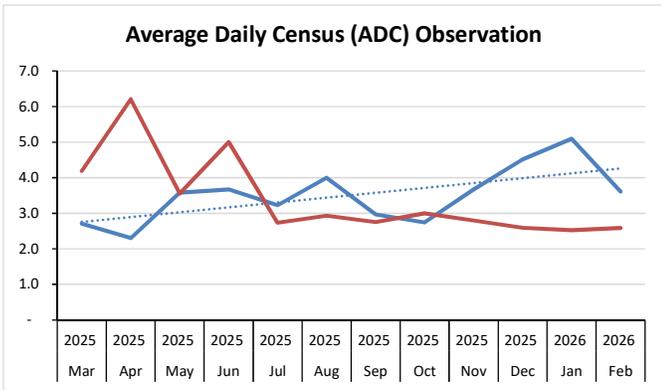
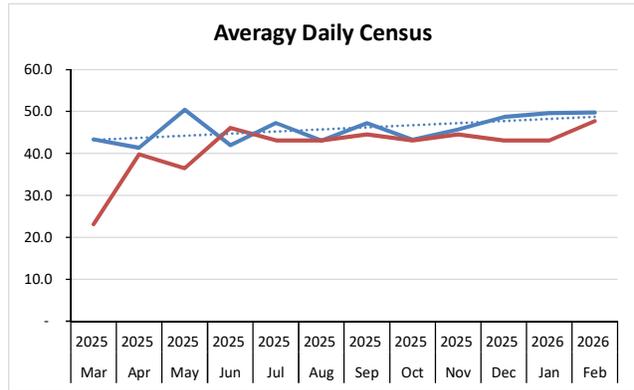
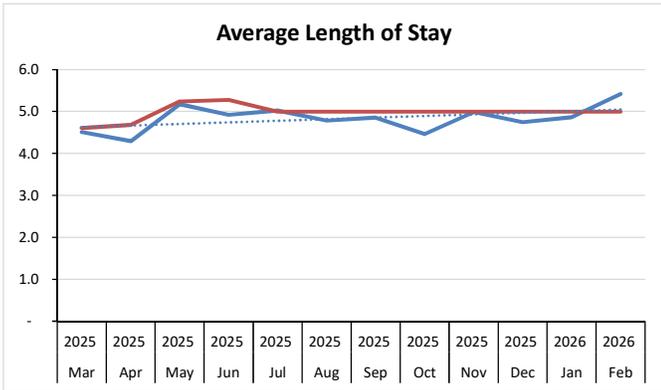
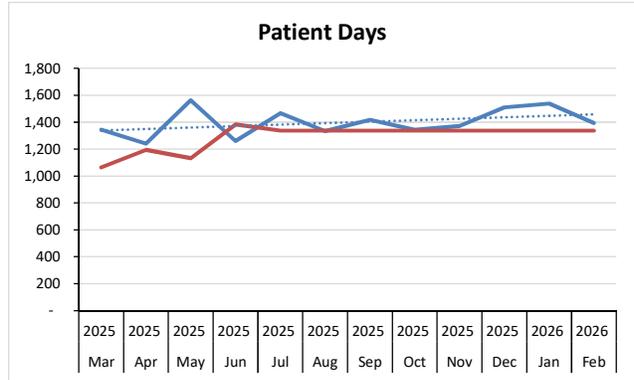
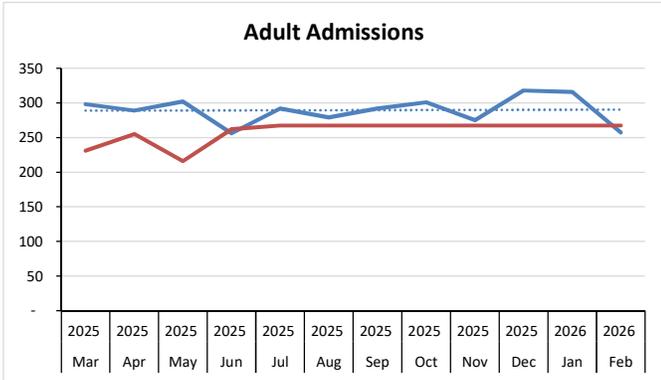
**EI Centro Regional Medical Center**  
**Monthly Cash Flow**

*Unaudited*

	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	January 2026	February 2026	Year-to-Date 2026
<u>Cash Flow From Operating Activities</u>									
Net Income/(Loss)	\$ 1,531,620	\$ (928,870)	\$ (4,964,247)	\$ (2,060,067)	\$ (1,295,258)	\$ (684,345)	\$ (281,271)	\$ (1,447,870)	\$ (10,130,308)
<i>Adjustments to reconcile net income to net cash:</i>									
Add: Depreciation	576,457	570,465	548,724	555,687	227,580	543,389	544,312	472,945	\$ 4,039,559
Capital Lease Interest	4,729	4,807	4,518	4,063	3,656	3,067	3,405	3,152	\$ 31,397
Bond Interest	578,211	578,211	578,211	578,211	578,211	578,211	578,211	578,211	\$ 4,625,686
Accounts Receivable	181,484	117,559	5,349,354	2,077,513	893,317	(675,118)	2,110,013	385,832	\$ 10,439,954
Other Receivables	161,635	(26,032)	(19,841)	(50,501)	23,728	(3,575)	(19,932)	55,134	\$ 120,615
Inventory	(22,343)	(46,520)	1,424	1,141	12,225	3,756	18,774	1,247	\$ (30,294)
Prepaid Expenses/Other Assets	(696,936)	477,026	(95,484)	66,263	58,132	(79,410)	71,369	36,749	\$ (162,290)
Accounts Payable and Accrued Expenses	1,035,816	1,216,039	340,127	(1,502,650)	736,667	185,428	337,133	2,038,398	\$ 4,386,959
Accrued Compensation and Benefits	(1,907,284)	211,863	427,550	561,175	444,359	(1,736,148)	31,743	93,384	\$ (1,873,359)
Third-Party Liabilities	(2,473,448)	(3,782,432)	(1,812,277)	631,228	(5,689,044)	3,589,782	(2,713,285)	(7,111,139)	\$ (19,360,615)
Net Pension Obligation	719,600	710,137	719,600	710,134	4,719,600	719,600	(3,280,400)	8,710,282	\$ 13,728,553
<i>Net Cash From Operating Activities</i>	\$ (310,459)	\$ (897,746)	\$ 1,077,659	\$ 1,572,197	\$ 713,173	\$ 2,444,636	\$ (2,599,928)	\$ 3,816,325	\$ 5,815,857
<u>Cash Flow From Investing Activities</u>									
Fixed Assets - Gross	\$ (804,470)	\$ (518,646)	\$ (691,873)	\$ (599,649)	\$ (52,014)	\$ (390,293)	\$ (409,492)	\$ (1,380,674)	\$ (4,847,112)
Intangible Assets - Gross	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Restricted Assets	3,912,524	(666,888)	(669,248)	(670,923)	(673,488)	(675,078)	2,539,509	(668,923)	\$ 2,427,485
<i>Net Cash From Investing Activities</i>	\$ 3,108,054	\$ (1,185,535)	\$ (1,361,121)	\$ (1,270,572)	\$ (725,503)	\$ (1,065,371)	\$ 2,130,017	\$ (2,049,597)	\$ (2,419,628)
<u>Cash Flow From Financing Activities</u>									
Bond Payable	\$ (4,719,631)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ (3,344,369)	\$ -	\$ (8,064,000)
Capital Leases	(234,766)	(240,557)	(286,507)	(238,790)	(183,988)	(220,862)	(245,774)	(214,345)	\$ (1,865,590)
Notes Payable	-	-	-	-	-	-	-	-	\$ -
<i>Net Cash From Financing Activities</i>	\$ (4,954,397)	\$ (240,557)	\$ (286,507)	\$ (238,790)	\$ (183,988)	\$ (220,862)	\$ (3,590,143)	\$ (214,345)	\$ (9,929,590)
<i>Total Change In FY 2026 Cash</i>	\$ (2,156,803)	\$ (2,323,837)	\$ (569,969)	\$ 62,835	\$ (196,318)	\$ 1,158,403	\$ (4,060,054)	\$ 1,552,382	\$ (6,533,360)
<i>Cash &amp; Cash Equivalents, Beginning Balance</i>	9,817,742	7,660,939	5,337,101	4,767,132	4,829,967	4,633,650	5,792,053	1,731,999	9,817,742
<i>Cash &amp; Cash Equivalents, Ending Balance</i>	\$ 7,660,939	\$ 5,337,101	\$ 4,767,132	\$ 4,829,967	\$ 4,633,650	\$ 5,792,053	\$ 1,731,999	\$ 3,284,381	\$ 3,284,381

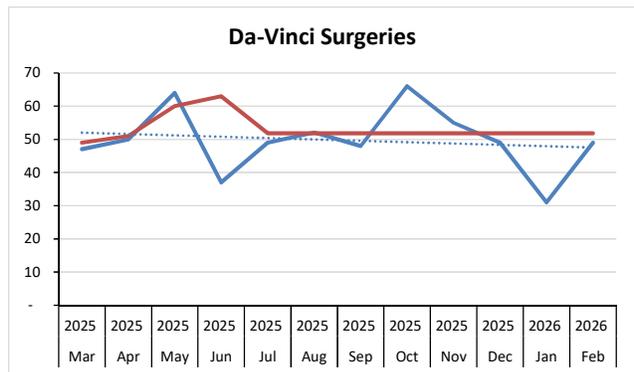
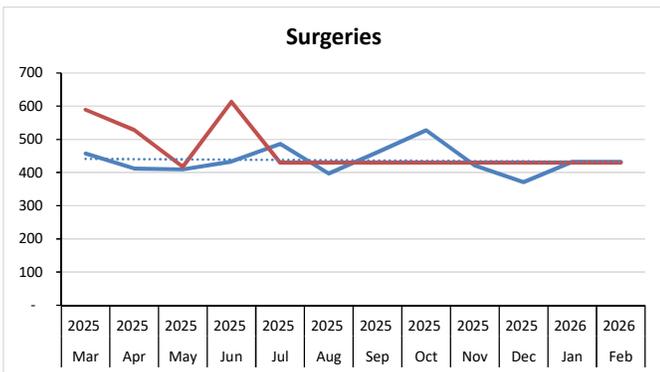
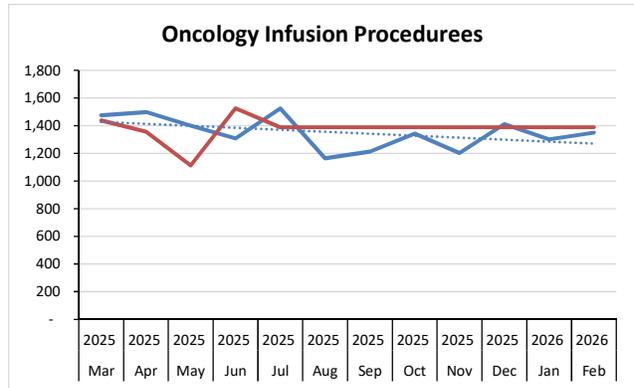
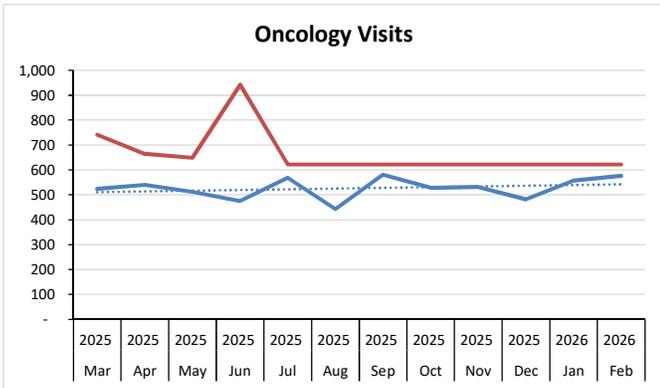
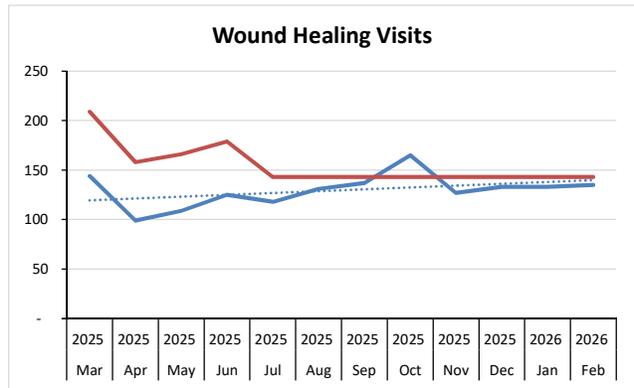
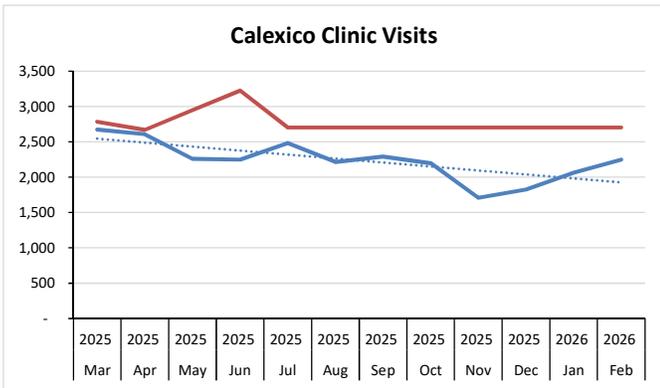
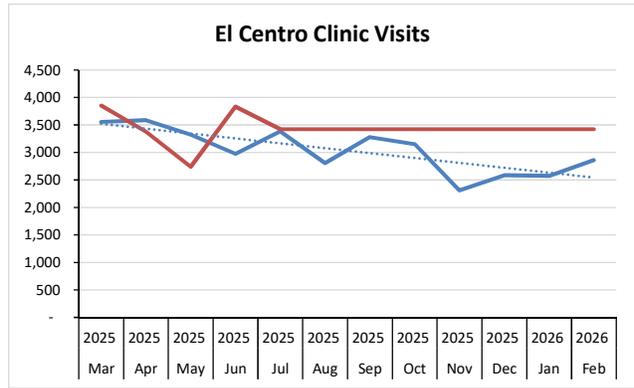
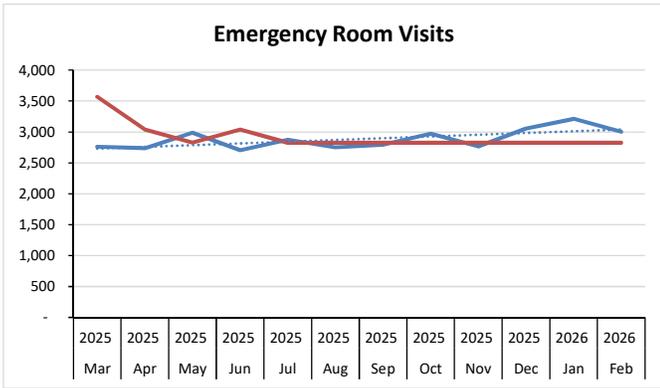
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# El Centro Regional Medical Center Rolling-12 Volume trend



█ BUDGET  
█ ACTUALS

# El Centro Regional Medical Center Rolling-12 Volume trend



█ BUDGET  
█ ACTUALS