TORRANCE MEMORIAL MEDICAL CENTER

| Applicant Name: | |
|---|---|

**Thank you for your interest in Torrance Memorial Medical Center.** If you are interested in applying to the Medical Staff, please review the information listed below and submit the attached form.

**1. QUALIFICATIONS FOR MEMBERSHIP**

**A.** Please refer to the Medical Staff Bylaws, Article III, Section 3.2. The Medical Staff Bylaws may be reviewed on the Torrance Memorial Medical Center website by clicking this link: https://www.torrancememorial.org/For_Physicians.aspx

**2. THE FOLLOWING CRITERIA MUST BE MET PRIOR TO APPLYING**

**A.** Current California Medical License
**B.** Current DEA Certificate
**C.** Current Curriculum Vitae
**D.** Currently have or are actively engaged in acquiring professional liability insurance policy with limits of coverage in the amounts of $1 million per occurrence and $3 million aggregate per physician per year, commensurate with the privileges you will be requesting. Policy must be in effect before the completion of the application process
**E.** Not currently excluded or denied participation from any health care program funded in whole or in part by the federal government or any state health care program including, but not limited to, Medicare or Medi-Cal and are not aware of any pending actions regarding potential exclusions from these programs
**F.** Have provider coverage in your absence with provider(s) currently on staff at Torrance Memorial Medical Center or provider is a current applicant. Covering provider must hold same privileges as applicant.

**3. PHYSICIAN ACCOUNTABILITY**

Upon becoming a member of the Medical Staff of Torrance Memorial Medical Center applicants must agree to adhere to the following professional responsibilities, including complying with any regulatory requirements. The following documents may be reviewed on the Torrance Memorial Medical Center website by clicking this link: https://www.torrancememorial.org/For_Physicians.aspx

**A.** Medical Staff Bylaws (including continuous care of patient)
**B.** Medical Staff /General Staff rules and regulations (including participation in the Emergency Room Call Panel)
**C.** Medical Staff Department rules and regulations
**D.** Medical Staff Policy and Procedures (including Disruptive Behavior policy)
**E.** Proctoring Policy (including serving as a proctor on a rotating basis)

**4. APPLICATION FEE**

**A.** Application Fee of $600.00 (non-refundable)

**5. PHYSICIAN ORIENTATION**

All physicians must attend physician orientation prior to being formally appointed. *In accordance with the Medical Staff Bylaws of Torrance Memorial Medical Center, Article VI, Paragraph 6.2, Burden of Producing Information: The time frame for completion of orientation for applicants shall be sixty (60) business days following the date of approval of the application by the department chief. Failure to complete the orientation within this time frame shall be deemed* ***a voluntary withdrawal of the application****.*

A hospital badge and parking access will be provided during orientation. You will be required to bring the following documents to orientation.

**A.** **Current Driver's License or other government issued identification**. Please note that The Joint Commission requires that we physically verify a current original government issued identification (i.e. driver's license/passport) of each applicant.

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**B. Flu Documentation (required November thru April 30 only):**

- Please submit a copy of your current year flu documentation.
- Flu Declination: There are two methods for declining the flu vaccine: Medical Exemption and Religious Accommodation. The medical exemption form must be completed by your physician and should be filled out completely including the physician's signature. The religious accommodation must be completed by you. Please contact the Medical Staff Services Department at (310) 517-4616 prior to orientation to request the form. After the form has been submitted, it will be evaluated for approval.

***All applicants must provide the required documentation prior to the application link being provided.***
***All applicants without an approved medical exemption or religious accommodation will be required to get the flu vaccine or you may not be issued temporary privileges.***

**C. COVID -19 Vaccination Documentation (required November thru April 30 only)**

- Please submit a copy of your COVID -19 vaccination for the **current** respiratory illness season.
- Acceptable forms of documentation are: COVID -19 Vaccination Record Card (CDC white card/WHO yellow card); A photo of Vaccination Record Card (paper or on electronic device); Documentation of COVID -19 vaccination from a healthcare provider or a Digital record that includes a QR code, client name, vaccine dates and vaccine type
- COVID -19 Declination: If you decline the current COVID-19 vaccine, you must complete and submit a declination form and wear a mask for the entirety of the respiratory illness season.

***All applicants must provide the required documentation prior to the application link being provided.***

***Those who have received the previous bivalent COVID-19 vaccine within the last two months will not be eligible to receive the updated COVID-19 vaccine at this time. Once the two-month period has passed, applicants will be required to comply with the health order and either choose to receive the 2023-24 COVID-19 vaccine or signed declination form.***
***(2023–2024 formula) mRNA COVID vaccine***

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**To request a link to the online application please complete the information listed below. This form must be typed.**

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| Physician Name & Title (M.D. D.O. D.P.M. etc.): | |
| Group Name (if applicable): | |
| Primary Specialty: | |
| Secondary Specialty (if applicable): | |
| Gender: | |
| Date of Birth: | |
| Social Security Number: | |
| NPI Number: | |
| Practice Address: | |
| City: | |
| State: | |
| Zip: | |
| Office Phone Number: | |
| Office Fax Number: | |
| Cell Phone Number: | |
| **Email Address:** **(must be your individual email address)** | |

**Your Credentialing Staff to receive copy of the application link (if applicable):**

| | |
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| First Name & Last Name: | |
| Title (i.e. Office Manager): | |
| Office Phone Number: | |
| **Email Address:** **(must be an individual email address, may not be same as physician email address)** | |

**The provider that will provide coverage in your absence. Must be currently on staff at Torrance Memorial Medical Center or provider must be a current applicant**

| | |
|---|---|
| Physician Name: | |
| Primary Specialty: | |
| Practice Address: | |
| City: | |
| State: | |
| Zip: | |
| Office Phone Number: | |

Application fee of $600 is non-refundable.
By signing below, I attest that I have read and understand the qualifications for Medical staff eligibility.

Physician Signature:_____

Printed Name: _____

Date: _____

Return form to _MSOOnlineApplication@tmmc.com (please note there is an underscore at the beginning of the email address)