TITLE: Emergency/Disaster Privileges for Volunteer Licensed Independent Practitioners & Advanced Practice Professionals

REFERENCE: TJC MS.01.01.01 EP 14; EM.02.02.13; CA Business & Professions Code Section 900

POLICY:
Licensed independent practitioners (LIPs) and Advanced Practice Professionals (APPs) who are not members of the Medical Staff of UCSD Health (UCSDH) and who do not already possess clinical privileges to practice at UCSDH, may be granted volunteer disaster privileges if both of the following occur: (1) the UCSDH Emergency Operations Plan is in effect; and (2) UCSDH is unable to handle the immediate patient needs as determined under the Hospital Incident Command System (HICS) and authorized by the Hospital Incident Commander. Whether it is a local, state, or national emergency, the Chief Executive Officer (CEO) or his/her designee(s) may grant disaster privileges and such decision(s) to grant privileges shall be made on a case-by-case basis.

DEFINITIONS:

Advanced Practice Professionals (APPs): means an individual, other than a LIP, who exercises independent judgment within the areas of his/her professional competence and the limits established by the Executive Governing Body, the Medical Staff, and the applicable state practice act, who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Medical Staff Member possessing privileges to provide such care in at UCSDH in conformity with the Bylaws, Policies, Plans, and Rules.

Licensed Independent Practitioners (LIPs): means a licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, who exercises independent judgment within the areas of his/her professional competence and the limits established by the Executive Governing Body, the Medical Staff, and the applicable state practice act.

Member of the Medical Staff: means any practitioner who has been appointed to the Medical Staff.

PROCEDURE:

1. **IDENTIFICATION:** The Chief Executive Officer (CEO) or his/her designee(s) may grant disaster volunteer privileges to practitioners following the presentation of a valid government-issued photo identification (e.g. driver’s license or passport) AND at least one of the following:
   A. Licensure:
      1) Current license to practice in California by an appropriate state licensing board; or
      2) When the California Director of Emergency Services declares, pursuant to California Business and Professions Code Section 900, that licensed healthcare practitioners from other states may provide services during a disaster, a current professional license to practice from another state may be accepted.
   B. Confirmation by currently privileged UCSDH Medical Staff or staff member(s) who possesses personal knowledge regarding volunteer’s ability to act as a practitioner during a disaster; OR
   C. Primary source verification of the license; OR
   D. Current hospital picture identification card that clearly identifies professional designation; OR
   E. Picture identification which indicates that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration for Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups that themselves require ongoing proof of licensure; OR
   F. Picture identification which indicates that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.
   G. All practitioners who seek disaster privileges must fill out a copy of the Emergency/Disaster Privileges for Licensed Independent Practitioners Privilege Form.
      1) Those practitioners whose credentials cannot be verified will not be granted disaster privileges.

2. **BADGE:** If resources are available, the practitioner will be provided a UCSDH photo ID Badge. The practitioner’s current photo ID or current photo ID badge may be modified for use as a temporary UCSDH ID badge if resources are not available to produce an original UCSDH photo ID Badge.
3. **IDENTIFICATION:** Medical Staff Administration will assign the disaster volunteer with a PID (physician identification) number.

4. **VERIFICATION OF INFORMATION:** Medical Staff Administration shall perform primary source verification of the licensure of practitioners who receive volunteer disaster privileges as soon as the immediate situation is under control or within 72 hours from the time the volunteer practitioner presents to UCSDH, whichever comes first.
   A. A written record of the information and verification(s) shall be retained in Medical Staff Administration utilizing the attached *Emergency/Disaster Privileges for Licensed Independent Practitioners Privilege Form*.
   B. When emergency verifications are complete the Chief Executive Officer (CEO) or designee(s) will be notified to approve the request for Disaster/Emergency privileges.
   C. The Chief Executive Officer (CEO) or designee(s), must make a decision within 72 hours related to the continuation of the disaster privileges initially granted based on information obtained regarding the professional practice of the volunteer.
   D. In the extraordinary circumstance where primary source verification cannot be completed in 72 hours (*e.g.* no means of communication or lack of resources), it is expected that it will be accomplished as soon as possible. In this extraordinary circumstance, documentation will include the following:
      1) Why primary source verification could not be performed in the required time frame;
      2) Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and
      3) An attempt to rectify the situation as soon as possible.
   E. Primary source verification of licensure is not required if the volunteer practitioner has not provided care, treatment, and services under the volunteer disaster privileges.

5. **CONDITIONS OF DISASTER PRIVILEGES:**
   A. **SUPERVISION:** The practitioner granted disaster privileges shall be assigned to an existing member of the Medical Staff, in the same specialty if possible, for oversight of patient care rendered. The practitioner with disaster privileges shall practice under the direction and supervision of the Medical Staff Member.
   B. **MONITORING:** The responsible Department Chair will monitor the professional performance of the volunteer practitioner granted disaster privileges by either direct observation, mentoring, and/or clinical record review.
   C. **ATTESTATION:** The practitioner granted disaster privileges shall, by signed statement:
      1) Attest that all information provided by him/her is true and accurate;
      2) Be bound by all hospital policies and procedures, rules and regulations and the Medical Staff Bylaws, and any directives from the Chief Medical Officer, Chief of Staff, Department Chair, supervising physician or any other hospital or Medical Staff leader; and
      3) Agree to defend, indemnify and hold harmless The Regents of the University of California for all acts and omissions.
   D. **RIGHTS:** The practitioner granted volunteer disaster privileges shall not be afforded the corrective action, hearing, and appeal procedure rights available to applicants, APPs, and Members of the Medical Staff as defined in the Medical Staff Bylaws, Plans, Rules and Regulations, or Policies.

6. **TERMINATION OF PRIVILEGES:**
   A. Disaster volunteer staff privileges will terminate when one of the following occurs:
      1) In the event any information is received that suggests the practitioner is not capable of rendering services in an emergency or a previously accepted license is shown to have been suspended;
      2) When the practitioner’s services are no longer needed; or
      3) When the UCSDH Emergency Operations Plan is inactivated.

<table>
<thead>
<tr>
<th>APPROVALS:</th>
<th>Approved:</th>
<th>Revised:</th>
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</thead>
<tbody>
<tr>
<td>Medical Staff Administration</td>
<td>04/18/06</td>
<td>07/28/08; 11/04/08; 09/02/2011; 03/31/2020</td>
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<td>Credentials Committee</td>
<td>08/02/06</td>
<td>08/01/2007; 10/01/2008; 11/5/08; 09/07/2011; 4/1/2020</td>
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<td>Medical Staff Executive Committee</td>
<td>08/22/06</td>
<td>08/16/2007; 10/16/2008; 11/20/08; 11/19/08; 09/15/2011; 04/2/2020</td>
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<td>Executive Governing Body</td>
<td>08/22/06</td>
<td>08/16/2007; 10/16/2008; 11/20/08; 11/19/2009; 09/15/2011; 04/2/2020</td>
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</table>
# EMERGENCY/DISASTER PRIVILEGES APPLICATION FORM

**Emergency Management Activation Plan**

Activated: Date: ___ Time: ________

REFERENCE: TJCM.01.01.01 EP 14; EM.02.02.13; CA Business & Professions Code Section 900; MSP 004

## IDENTIFYING INFORMATION

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<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>MAIDEN NAME</th>
<th>OTHER NAME</th>
<th>SEX</th>
</tr>
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PLACE OF BIRTH | DATE OF BIRTH

CITIZENSHIP | IN NOT USA, GIVE STATUS OF VISA/WORK PERMIT

OFFICE ADDRESS | CITY | STATE | ZIP CODE | AREA CODE/TELEPHONE #

HOME ADDRESS | CITY | STATE | ZIP CODE | AREA CODE/TELEPHONE #

**TYPE OF PHOTO I.D. REQUIRED** – State or Federal government-issued (e.g. driver’s license or passport) ATTACH COPY NUMBER

PHOTO I.D. (DMAT, or MRC, ESAR-VHP, or other – list) ATTACH COPY NUMBER

PHOTO I.D. (Other) ATTACH COPY NUMBER

**SPECIALTY IN WHICH VOLUNTEER DISASTER PRIVILEGES ARE DESIRED**

- [ ] Anesthesiology
- [ ] Neurosurgery
- [ ] Psychiatry/Psychology
- [ ] Dermatology
- [ ] Ophthalmology
- [ ] Radiology
- [ ] Emergency Medicine
- [ ] Orthopedic Surgery
- [ ] Radiation Oncology
- [ ] Family Medicine/Preventive Med.
- [ ] Pathology
- [ ] Reproductive Medicine
- [ ] Medicine – Subspecialty?
- [ ] Pediatrics
- [ ] Surgery – Subspecialty?
- [ ] Neurology
- [ ] Podiatry
- [ ] Urology

## CURRENT HOSPITAL AFFILIATION

<table>
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<tr>
<th>FACILITY NAME</th>
<th>STAFF STATUS</th>
</tr>
</thead>
</table>

ADDRESS | CITY | STATE | ZIP | BADGE PROVIDED

**UCSDH REFERENCE**: Name of current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer’s ability to act as a licensed independent practitioner during a disaster

<table>
<thead>
<tr>
<th>NAME</th>
<th>TELEPHONE #</th>
<th>RELATIONSHIP</th>
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## STATE LICENSURE DATA

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<tbody>
<tr>
<td>B.</td>
<td>State</td>
<td>Number</td>
<td>Date of Expiration</td>
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## DRUGS AND NARCOTICS REGISTRATION

DEA registration number | Date issued | Expiration Date

[ ] Check here if you do not prescribe controlled substances and do not possess registration with the DEA.
PROFESSIONAL LIABILITY INSURANCE CARRIER(S) IF OTHER THAN UC REGENTS:

<table>
<thead>
<tr>
<th>NAME OF CARRIER</th>
<th>POLICY NUMBER</th>
<th>DATES OF COVERAGE</th>
</tr>
</thead>
</table>

RELEASE OF INFORMATION/CONSENT/ATTESTATION

By my signature below, I hereby volunteer my clinical services to UC San Diego Health during this emergency/disaster situation and agree to practice as directed by UC San Diego Health. I also agree to wear an ID Badge issued by UC San Diego Health at all times while providing services pursuant to the Disaster privileges granted to me.

I attest that all information provided in this Application is true and accurate. I certify that I have not had a professional license that has been revoked or suspended in any State or possession of the United States. I further certify that my privileges, membership, employment, and/or ability to practice at another healthcare institution have never been suspended, terminated, revoked, or denied.

I agree to be bound by all UC San Diego Health policies and procedures, rules and regulations and the Medical Staff Bylaws, Rules and Regulations, and policies. I also agree to follow any directives from the Chief Medical Officer, Chief of Staff, Department Chair, Division Chief, Medical Director, supervising physician, or any other UC San Diego Health or Medical Staff leader.

I agree to defend, indemnify, and hold harmless The Regents of the University of California for all acts and omissions.

*I acknowledge and agree that my temporary disaster privileges at UC San Diego Health shall immediately terminate once the emergency has ended, as notified by UC San Diego Health, and that these privileges may be terminated at any time without cause or reason, and without right to a hearing or review.*

______________________________

Signature

DATE:________________________

THIS SECTION TO BE COMPLETED BY MEDICAL STAFF ADMINISTRATION

PRACTITIONER TO BE SUPERVISED BY: ________________________________

(MUST be a member of UCSDH Medical Staff)

DATE UCSDH BADGE PROCESSED: _______/_____/_____

PHYSICIAN IDENTIFICATION NUMBER: ____________________________

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1. HOSPITAL AFFILIATION VERIFICATION DATE: _______________ GOOD STANDING: __________

2. UCSDH REFERENCE VERIFICATION DATE: ________________________________

3. STATE LICENSE VERIFICATION DATE: ___________________________ STATUS: __________

4. OTHER STATE LICENSE: _______________ DATE VERIFIED: _______________ STATUS: __________

Verified By: ___________________________ Date: ___________________________

Date Privileges Terminated: ___________________________