



Memorandum

Date: February 19, 2010

To: Attending and Associate category Members of the
Cedars-Sinai Medical Center Medical Staff

From: Scott Karlan, M.D., Vice Chief of Staff

Re: July 2010 – July 2012 Medical Staff Committee Assignments

Dear Colleague:

If you are on a Medical Staff Standing Committee or have served as a Standing Committee member in the past, allow me to express my appreciation. I hope that this was more than just a chore, but allowed you to address issues of concern to you. I also hope that you will be willing to volunteer again. If you have not served on a committee recently, please review our “Committee Questionnaire” form (attached) and consider whether your expertise, interests and concerns might help us to make better decisions. Cedars-Sinai is most likely to meet your needs if you participate in Medical Staff governance.

Committee appointments will be based on your expressed areas of interest, although we will also try to assure that different specialties are represented and that there is a mix of experienced and new members. Historically 80% of volunteers have been appointed to a Committee. We hate to turn down a volunteer, but there simply aren't enough seats to appoint everyone. For those not assigned to a Committee, we encourage involvement through Special Task Forces. If you are selected to serve on a Committee, you will be notified at the beginning of June for service effective July 1, 2010.

We have changed the process this year to comply with our Constitution and Medical Staff Rules and Regulations. **Please carefully follow the instructions below.**

To be considered for Committee appointment, you must:

1. **Complete the Committee Questionnaire request form** (attached). Please indicate which Committee(s) you currently serve on, then under 2010-2012, “Committee Preferences,” select any two Committees and rank them in order of preference.
2. **Submit the completed Committee Questionnaire to the Office of the Chief of Staff at: ChiefofStaff@cshs.org using your Cedars-Sinai Medical Center Exchange email account by April 19, 2010.** We will **NOT** accept Questionnaires from Medical Staff members who do not have a Cedars Exchange account, do not know how to use it, or choose to use alternative means (U.S. Mail, non-Cedars Email accounts, FedEx, UPS, personal delivery, etc.).¹
3. **Complete the 2010 Conflict of Interest Questionnaire online by April 19, 2010.** The Questionnaire can be found at <https://apps2.csmc.edu/coistart/wwwindex.html>. For those on 2009 Committees, you will soon receive an email from Internal Audit with your 2010 log-in I.D. You will then be able to complete your COI. For those who do not receive an email from Internal Audit or for those who know that they need a log-in I.D., please call Internal Audit at (323) 866-6900.²

You will not be considered for committee appointment unless all three conditions have been met by April 19, 2010

If you already have a Cedars Exchange email account, skip this paragraph. For those who don't, we require an Exchange e-mail account for participation on all Standing Committees. All meeting notices, information and Minutes (if applicable) are sent to committee members by email. Confidential documents, including Minutes, are stored in a restricted Public Folder on Cedars' Exchange email system. **If you need an Exchange email account, please fill out the attached "Computing Account Authorization Form" and fax it immediately to EIS at (310) 423 - 0215. (Know that it takes EIS 48 to 72 hours from receipt of the Form to create an Exchange email address.)**

Note: You will not be automatically reappointed to a Committee on which you currently serve. If you wish to remain on your current Committee, you must return the completed Committee Questionnaire request form and comply with all of the above requirements. We will also be considering your prior participation and attendance. If you did not attend one-half (1/2) of the meetings in any one (1) calendar year, you may not be eligible to serve on that Committee.³

If you have any questions, please contact the Office of the Chief of Staff at (310) 423-5133.

Thank you,



¹Rules & Regulations, Section 11.10.1 "Basic Computer Literacy Requirements."

Pursuant to Article III of the Constitution, all Medical Staff Members must provide evidence of basic computer literacy and competency as determined by the Medical Executive Committee from time to time. ...Such basic Medical Staff computer literacy requirements shall include, without limitation:... (3) designation and use of an e-mail address, unless the Medical Staff Member participates on a Medical Staff committee whereupon a Medical Center Exchange e-mail address is required.

² Rules and Regulations, Section 25.2 "Conflicts of Interests."

Prior to sitting on a Standing Committee and on an annual basis thereafter, each Medical Staff Member shall submit a completed "Conflict of Interests Questionnaire," as required by the Medical Center's "Conflict of Interests Policy." The Secretary of the Medical Staff shall review and verify the members' Conflict of Interest Questionnaire.

³ Rules and Regulations, Section 12.2 "Failure to Attend Meetings."

Members not present for one-half (1/2) of the meetings of a Committee or special task force in any one (1) calendar year may not be reappointed to that Committee or special task force. The member will not be given credit for the calendar year's service.



CEDARS-SINAI MEDICAL CENTER.

**Medical Staff Committee Assignment Request Form
July 2010 – July 2012 Term**

PRINT NAME _____ **ID#** _____

EXCHANGE EMAIL ADDRESS _____ **@CSHS.ORG ***

**Note: Required for those who chose to serve on a Medical Staff Committee*

COMMITTEE	MEETING SCHEDULE / FREQUENCY	CURRENT MEMBER	FIRST CHOICE	SECOND CHOICE
BIOETHICS COMMITTEE	Monthly. First Thursday 11:30am – 1:00pm Harvey Morse 4 & 5			
CANCER COMMITTEE	Meetings in February May, July, October, December. Second Tuesday. 12:00 – 1:00pm Cancer Center Conference Room			
CONTINUING MEDICAL EDUCATION COMMITTEE	Bi-Monthly. Fourth Friday. 7:30 – 8:30am Room 2806			
HEALTH INFORMATION COMMITTEE	Monthly. Third Thursday. 12:00 – 1:00pm Harvey Morse 4 & 5			
PHARMACY & THERAPEUTICS COMMITTEE	Bi-Monthly. First Tuesday. 7:30 – 9:00am ECC-A			
PHYSICIAN / NURSE JOINT PRACTICE COMMITTEE	Monthly. Second Tuesday. 7:30 – 9:00am Nursing Conference Room #2007			



COMPUTING ACCOUNT AUTHORIZATION FORM - DOCTORS AND THEIR OFFICE STAFF

STATEMENT OF CONFIDENTIALITY: I understand that it is the Policy of (CSHS) to respect and maintain the confidentiality of all Confidential Health Information with respect to all patients of Cedars Sinai Health System. For purposes of this request, patient "Confidential Health Information" shall include without limitation, all Confidential Health Information regarding a patient's: (1) Medical treatment and condition; (2) Psychiatric and Mental Health; and (3) Substance abuse and Chemical dependency, which CSHS Personnel may receive pursuant to their relationship with CSHS, and shall include without limitation, the following patient identifiable information: (1) Name; (2) Address, including street address, city, county, zip code and equivalent geocodes; (3) Names of relatives; (4) Names of employers; (5) Date of birth; (6) Telephone numbers; (7) Facsimile number; (8) Electronic mail address; (9) Social security number; (10) Medical record number; (11) Health plan beneficiary number; (12) Account number; (13) Certificate/license number; (14) Any vehicle or other device serial number; (15) Web Universal Resource Number (WURL); (16) Internet Protocol (IP) address number; (17) Finger or Voice prints; and (18) Photographic images; and (19) Any other unique identifying number, characteristic, or code that may be available to CSHS Personnel which could be used, alone or in combination with other information, to identify an individual. I understand that in addition to patient Confidential Health Information, during the scope of my employment or other service relationship with CSHS, it may be necessary for me to receive, review, and work with certain other confidential and proprietary information of CSHS that may relate to CSHS's financial and other business information and/or records regarding CSHS's operations, business plans and employees. For purposes of this statement such information and patient Confidential Health Information defined above, are referred to herein collectively as "Confidential Information."

ACCOUNT AGREEMENT: I understand that no Confidential Information may be accessed, discussed, or released without having the proper authorization to do so. Any access, discussions or release of Confidential Information shall only be for purposes of patient care and/or CSHS business and shall be on a "need to know" basis (i.e., in order to carry out the duties necessary for my employment or other services provided to CSHS). Access shall also be limited to the "minimum necessary" information to achieve the purpose of the access. Access, disclosure or release includes, without limitation, the access of any electronic or paper-based Confidential Information. (More specifically stated in signed CSHS Confidentiality Statement) I further understand that I will be issued a unique Username and Password which I will keep confidential and will not reveal to anyone, and that if I discover that the confidentiality of my Password has been compromised, I will change it immediately and promptly notify EIS Data Security. By indicating my signature below, I attest that I have reviewed and understand the foregoing statements and agree to be bound by the terms and conditions herein and the relevant CSHS policies and procedures regarding computer usage and confidentiality, and that any failure on my part to comply with the terms set forth herein and in such policies will subject me to disciplinary action which may include immediate termination of my employment and/or legal action as deemed appropriate.

Note: Bolded fields are mandatory. Fields must be complete or the request will be returned.

Last Name: _____ First _____ MI _____
Please Print Clearly **Please Print Clearly**

Title: M.D. (CSHS MD#: _____) R.N. Certification/Degree _____ Other: _____

Social Security#: _____ - _____ - _____ Mother's Maiden Name* _____

*An Alternate name can be listed for security purposes

Office/Loc _____ Depart. Phone#:() _____ Fax:() _____ Email Address _____

Department/Division: _____

Designation: CSHS Employee (Supervisors Name) _____ Job Title: _____

CSHS Faculty Physician Specialty: _____

Resident/Fellow Expected Departure Date: _____ DEA#: _____

Medical Student Rotation Dates: Start: _____ End: _____

Private Practice Physician

Employee in a Private Physician Office - Physician Name & Signature: _____

Contractor/Consultant for Physician - Company Name & Contact: _____

Signature: _____ Date: _____

Send or FAX your completed application to: C.S.H.S. EIS 6500 Wilshire Blvd., Ste 400 – ATTN: Web/VS Support Team
Los Angeles, CA 90048 FAX: 310-423-0215