UNIVERSITY OF CALIFORNIA, RIVERSIDE

SCHOOL OF MEDICINE

VOLUNTEER CLINICAL FACULTY

ATTESTATION FORM IN SUPPORT OF APPOINTMENT OR RE-APPOINTMENT

1. I have a current, unrestricted license to practice _____ issued by the _____ (attach copy of current license).
   ☐ Yes, license number _____
   ☐ No, please explain _____

2. Have any of the following ever been, or are any of the following currently being voluntarily or involuntarily denied, revoked, suspended, relinquished, withdrawn, reduced, limited, not renewed, placed on probation or currently under investigation?
   a) Medical or professional license in any state ☐ No ☐ Yes, please explain _____
   b) DEA certificate of registration ☐ No ☐ Yes,please explain_____
   c) Membership on any hospital medical staff ☐ No ☐ Yes,please explain_____
   d) Clinical privileges on any medical staff ☐ No ☐ Yes, please explain _____

3. Have you ever been suspended or excluded by the federal government from participation in any governmental health care program or, to the best of your knowledge, been proposed for exclusion?
   ☐ No
   ☐ Yes, please explain _____

   I agree to notify the Department Chair and the Compliance Officer or the University's Office of General Counsel immediately upon receiving written or verbal notification that I am proposed for exclusion from any governmental health care program.

4. Do you hold Professional Liability Insurance coverage of at least $1 million per occurrence and $3 million aggregate (the minimum coverage required to practice medicine at UC)? *N.B. UC liability coverage for voluntary faculty is very limited and only covers activities that are conducted within the course and scope of their University appointment. It does not provide any coverage for the voluntary faculty member's own lapses, acts, or omissions.*
   ☐ Yes, please identify below
   ☐ No, if no:
   ☐ Not needed; UC teaching activities only
   ☐ Not mandated for specialty, e.g. nursing or pharmacy
   ☐ Other reason, please explain _____

MALPRACTICE CARRIER INFORMATION		
NAME OF CARRIER	POLICY NUMBER	DATES OF COVERAGE

5. Has your professional liability insurance ever been canceled, or has any professional liability insurer refused to renew your policy?
   ☐ No
   ☐ Yes, please explain_____

6. I UNDERSTAND THAT I HAVE AN ONGOING LEGAL DUTY TO IMMEDIATELY INFORM UCR SCHOOL OF MEDICINE, IN WRITING, IF THE _____ (LICENSING AUTHORITY) RESTRICTS OR REVOKES MY LICENSE OR IF MY PROFESSIONAL LIABILITY COVERAGE LAPSES, IS REVOKED OR EXPIRES OR IF ANY OF THE CIRCUMSTANCES DESCRIBED ABOVE OCCUR.

7. I UNDERSTAND THAT I MAY BE LIABLE FOR ANY AND ALL MONETARY DAMAGES OR EXPENSES INCURRED BY THE REGENTS OF THE UNIVERSITY OF CALIFORNIA ARISING FROM OR RELATED TO ANY MISREPRESENTATION, BREACH OF WARRANTY OR BREACH OF MY ONGOING DUTY TO INFORM THE UCR SCHOOL OF MEDICINE OF ANY OF THE ABOVE CHANGES IN LICENSURE OR INSURANCE COVERAGE.

I understand, acknowledge and agree that I have the burden of producing adequate information for proper evaluation of my experience, background, training, ability, professional ethics and/or resolving any doubts about these or any of the other qualifications for appointment as a member of the voluntary clinical faculty. I agree to provide such other and further information relating to the foregoing as the School of MEDICINE may require.

I, the undersigned applicant, hereby represent to the UCR School of MEDICINE that all information contained in the application is true, correct and complete in all material respects. I understand and acknowledge that any material misstatement in or omission from my application shall constitute cause for denial of this application and revocation of my faculty appointment.

Date: _____ Signature: _____

PRINTED NAME: _____