Ocean Plastic Surgery Center
10921 Cherry St. STE 200,
Los Alamtios, CA 90720
(562) 594-5996

Credentialing Application

Welcome to Next Level Surgery Center at Ocean Plastic Surgery Center

It is with great excitement that we welcome you to Next Level Surgery Center, the premier destination for plastic, aesthetic, and reconstructive surgery. Our vision is to elevate surgical excellence by providing an unparalleled environment where both patients and surgeons experience the highest standards of safety, precision, and care. At Next Level Surgery Center, our mission is to support exceptional surgical outcomes through cutting-edge technology, a highly trained team, and an unwavering commitment to sterility, safety, and efficiency. Our core values —Excellence, Integrity, Innovation, and Patient-Centered Care—guide everything we do.

We take pride in our state-of-the-art facility, fully AAAASF certified with an impeccable record of compliance and patient safety. Our center is designed to cater exclusively to plastic, aesthetic, and reconstructive surgery, ensuring that every aspect of our operations is tailored to the unique needs of surgeons. Our commitment to safety, sterility, and terminal cleaning ensures that every procedure is performed in an environment that upholds the highest medical standards.

What sets us apart:

- Exclusively Plastic Surgery-Trained Staff – Our team includes experienced board-certified anesthesiologists, plastic surgery-trained nurses, medical assistants, and scrub techs, all dedicated to seamless surgical flow and patient safety.
- Cutting-Edge Equipment & Surgical Tools – We invest in the latest advancements to optimize your ability to perform with precision and confidence.
- Surgeon-Focused Comfort & Efficiency – We understand what surgeons need to perform at their best. Our seamless scheduling, well-equipped surgical suites, and collaborative approach create an ideal environment for efficiency, comfort, and excellence.

The credentialing process typically takes up to 14 days for review and approval. To ensure a smooth process, please submit all required documentation promptly.

We are honored to have you join our esteemed team and look forward to fostering a productive, professional, and rewarding partnership. Welcome to Next Level Surgery Center—where surgical excellence reaches new heights.

Contents:

Return the following with application:

- ☐ Copy of current CA ID or DL.
- ☐ Copy of current Medical License.
- ☐ Copy of DEA registration
- ☐ Copy of Liability Insurance
- ☐ Copy of Immunization Records
- ☐ Copy of PPD test
- ☐ Copy of Diplomas
- ☐ Copy of all Certifications
- ☐ Separate sheet for expalanations (if applicable)

IDENTIFICATION INFORMATION

Last Name	First Name	Middle Initials	SSN
Professional Group Name and Address			
City	State	Zip	
Tel.#	Fax#	Email	
Home Address		Tel.#	
City	State	Zip	
Date of Birth	Place of Birth		
Physician providing coverage	Tel. #	Fax#	Email

MEDICAL LICENSURE/CERTIFICATION

CA License Number		Expires
DEA Number		
Other State Medical License	State	Expires

PREMEDICAL EDUCATION

College/University | Degrees/Honors

Address | Date of Graduation

MEDICAL EDUCATION

Medical School | Degrees/Honors

Address | Date of Graduation

Foreign Medical Graduate Exam in Medical Sciences, if applicable | Date

INTERNSHIP

Hospital | Dates Attended

Address | Name of Program Director

Type | Kind (medical, Surgical, etc.)

RESIDENCY(IES)

1

Hospital | Dates Attended

Address

Description | Name of Program Director

RESIDENCY(IES)

2

Hospital | Dates Attended

Address

Description | Name of Program Director

TRAINING, FELLOWSHIP, PRECEPTORSHIP, POSTGRAD EDUCAITON

List in chronological order. Give complete school or hospital name and address, including zip codes; beginning and ending dates; and the name of the immediate superior.

1

School or Hospital | Address

Dates | Superior

2

School or Hospital | Address

Dates | Superior

3

School or Hospital | Address

Dates | Superior

HOSPITAL AND UNIVERSITY AFFLIATIONS

List all present and past affiliations in chronological order. Indicate “Staff Status” as: Active/Courtesy, etc. or Academic Title.

1

Name of Institution

Address

Dates Affiliated

Staff Status

Department

Dept. Chief/Chairman

2

Name of Institution

Address

Dates Affiliated

Staff Status

Department

Dept. Chief/Chairman

3

Name of Institution

Address

Dates Affiliated

Staff Status

Department

Dept. Chief/Chairman

4

Name of Institution

Address

Dates Affiliated

Staff Status

Department

Dept. Chief/Chairman

PREVIOUS MEDICAL PRACTICE

1

Type	Location (full address/group name)	Dates Practicing
Type	Location (full address/group name)	Dates Practicing
Type	Location (full address/group name)	Dates Practicing

CERTIFICATION

2

Certified by American Board of (Specialty)	Certification #	Expires
Sub-specialty Board Status (Name of Board)	Certification #	Expires

If not certified, give present status

PROFESSIONAL SOCIETIES, AWARDED FELLOWSHIPS (ACS, ACP, ETC)

List all memberships past, present or pending in professional societies. Please include date of membership. Please give complete names and addresses, including ZIP codes in all instances. Attach additional sheeet if necessary.

PROFESSIONAL PEER REFERENCES

List three professional references familiar with the applicant's qualifications during the three years immediately preceding this applicaiton. One professional reference must be from the Chief of the department or service where the applicant last furnished professional services.

1

Name | Professional Relationship

Address | City | State | Zip

2

Name | Professional Relationship

Address | City | State | Zip

3

Name | Professional Relationship

Address | City | State | Zip

PROFESSIONAL LIABILITY

Insurance Carrier | Amout of Coverage

Policy# | Agent | Expiration Date

Have any professional liability law suits been filed against you during the past ten years (including those closed)?	☐ Yes	☐ No
Are there any now still pending?	☐ Yes	☐ No
Has any judgment or settlement ever been made against you in any professional liability cases?	☐ Yes	☐ No
Have you ever been denied professional insurance, or has your policy ever been cancelled?	☐ Yes	☐ No

If yes to any of the above, please explain on separate sheet.

PROFESSIONAL SANCTIONS

Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?	☐ Yes	☐ No
Have you ever been refused membership on a hospital medical staff?	☐ Yes	☐ No
Has your request for any specific clinical privleges ever been denied or granted with stated limitations?	☐ Yes	☐ No
Have your privliges at any hospital ever been suspended, diminished, revoked or not renewed?	☐ Yes	☐ No
Has your nartcotics registration ever been suspended or revoked?	☐ Yes	☐ No
Have you ever been denied membership or renewal thereof or been subject to disciplinary action (Other than discipline for failure to complete medical records) in any medical organization or health insurance plan'?		
Have you ever recieved a criminal conviction other than minor traffic violations?	☐ Yes	☐ No
Have you been sanctioned by either the medicare or medicaid program	☐ Yes	☐ No
If yes to any of the above, please explain on separate sheet.	☐ Yes	☐ No

Health Status

Have you had an illness or physical disability that impairs, or could impair your ability to practice your medical specialty?	☐ Yes	☐ No

If yes to any of the above, explain on separate sheet.

By applying for clinical privileges at Ocean Plastic Surgery Center, I hereby signify my willingness to provide necessary information and/or appear for an interview (if requested) regarding my application. I authorize Ocean Plastic Surgery Center, its Medical Staff, and their representatives to consult with the chief executive officers and members of the medical staffs of other hospitals, medical societies, health facilities, and any other individuals or organizations that may have relevant information regarding my professional competence, character, and ethical qualifications.

I further consent to the release of information from my present and past malpractice insurance carrier(s) and authorize Ocean Plastic Surgery Center and its Medical Staff to review all relevant records, including medical records at other hospitals, that may be material in evaluating my professional qualifications, competency in performing the clinical privileges requested, and my ethical qualifications for staff membership.

I hereby release from liability all representatives of Ocean Plastic Surgery Center, its Medical Staff, and any authorized agents for their actions performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. Additionally, I release from liability all individuals and organizations who, in good faith and without malice, provide information to Ocean Plastic Surgery Center or its Medical Staff concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges.

I authorize Ocean Plastic Surgery Center to communicate with other facilities, organizations, and individuals with a legitimate interest in my professional competence, character, and ethics. I consent to such communication made in good faith and without malice and agree to hold Ocean Plastic Surgery Center and its authorized representatives free from liability for such disclosures.

I understand and agree that, as an applicant for Medical Staff membership or privileges, I bear the burden of providing sufficient information for the proper evaluation of my professional competence, character, ethics, and other qualifications. I acknowledge my responsibility to resolve any doubts regarding my qualifications.

By accepting appointment and/or reappointment to the Medical Staff at Ocean Plastic Surgery Center, I acknowledge that I have read, understand, and adhere to the ethical and professional standards of national, state, and local medical associations, as well as all applicable state and federal laws governing my specialty and profession.

Additionally, I agree to promptly notify Ocean Plastic Surgery Center of any changes in my licensure, DEA registration, Medicare participation status, liability insurance coverage, Board certification status, or hospital privileges.

I understand and agree that any significant misstatements in or omissions from this application may result in denial of my appointment or summary dismissal from the Medical Staff without the right of appeal. I affirm that all information provided in this application is true and accurate to the best of my knowledge and belief.

I further authorize a photostatic copy of this authorization, release, and agreement to serve as the original.

Signature	Title	Date

Please PRINT or TYPE Name

MALPRACTICE CLAIMS FORM (If Applicable)

1. Name of Practicioner

2. Name of claimant

3. Insurance Company providing coverage

4. Please indicate the status of this claim by one of the following:

- ☐ Case Pending
- ☐ Case Resolved: verdict on your behalf
- ☐ Case Resolved: verdict on patient's behalf
- ☐ Case Resolved: settlement
- ☐ Case Resolved: abandoned by patient
- ☐ Other, specify

5. For pending claim, descrbe all activity on this claim within the last 12 months (e.g., testified at an EBT, verdict on appeal)

6. Were you ever served with a summons on this claim? ☐ Yes ☐ No

If YES:

A. When were you served with the summons?

B. Summons was issued in what court (e.g., Supreme Court_County, Federal Eastern or Southern District Court, Small Claims Court)

MALPRACTICE CLAIMS FORM (If Applicable) (Continued)

7. Date of occurrence giving rise to this claim

8. Location of treatment of patient (please check one):

- ☐ Doctor's office
- ☐ Clinic
- ☐ Hospital or Nursing Home
- ☐ Other, specify:

9. Nature of alleged incident:

I,

Declare that all the information contained on this malractice claims form is true and correct.

Signature Title Date

ACCEPTANCE STATEMENT

I have read and agree to abide by the bylaws, Rules and Regulations of the Ocean Plastic Surgery Center and all Policies and Procedures applicable to medical care.

Signature | Title | Date

Name (Please Print)

CONFIDENTIALITY AGREEMENT

Ocean Plastic Surgery Center maintains confidential medical information for the patients it serves. It is the responsibility of every employee, staff member, and authorized personnel to ensure that patient confidentiality is upheld and strictly adhered to at all times, in compliance with HIPAA regulations and all applicable privacy laws.

By affixing your signature below, you agree to maintain and protect patient confidentiality. You acknowledge that patient information should only be discussed when it is necessary for the provision of patient care or in accordance with authorized operational functions.

Any other release of patient information is strictly prohibited unless authorized in writing by the patient or as required by law.

Unauthorized disclosure, access, or discussion of patient information beyond the scope of permitted use may result in disciplinary action, including but not limited to termination of employment, revocation of privileges, and/or legal consequences.

By signing below, you acknowledge your understanding of this agreement and your obligation to uphold patient confidentiality at Ocean Plastic Surgery Center.

Print Name | Signature | Date

BACKGROUND CHECK AUTHORIZATION

I hereby authorize Ocean Plastic Surgery Center to conduct a background check as part of the credentialing process. This may include, but is not limited to, verification of my professional licensure, education, employment history, criminal record, and any other relevant background information necessary for determining my eligibility for employment or clinical privileges.

I understand that this background check will be conducted in compliance with all applicable federal and state laws. I consent to the release of any necessary information to Ocean Plastic Surgery Center or its designated agents for the purpose of completing this background check.

I acknowledge that any misrepresentation or omission of facts in my application may result in the denial of my application or termination of employment or privileges.

Print Name Signature Date

HEPATITIS B VACCINE DECLINATION

I understand that due to my occupational exposure to blood or other potentially infection materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine at no charge to myself; however, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with Hepatitis B Vaccine, then I can receive the vaccination series at no charge to me.

Signature Date

IMMUNIZATION REQUIREMENTS

To ensure a safe environment for patients and staff, Ocean Plastic Surgery Center requires all medical staff and employees to provide documentation of the following immunizations:

- Tuberculosis (TB) Screening – Proof of a negative TB test within the past 12 months or documentation of appropriate treatment if previously positive.
- Hepatitis B Vaccination – Proof of completed Hepatitis B vaccine series or a signed declination form if opting out.

Please attach copies of your immunization records or relevant medical documentation

PROVIDER BILLING INFORMATION

Legal Business Name (as registered with the IRS):

Billing Address | City | State | Zip

Billing Contact Person | Tel.# | Email Address

Tax Identification (TIN/EIN) Number

National Provider Identifier (NPI) Number

Medicare Provider Number (if applicable):

Medicaid Provider Number (if applicable)

Preferred Method of Payment: ☐ Direct Deposit (ACH) ☐ Check Payment

Bank Name (For ACH payments)

Routing Number:

Account Number:

Electronic Claims Submission Contact (if different from above):

Name | Tel.# | Email

I certify that the above billing information is accurate and up to date. I agree to notify Ocean Plastic Surgery Center of any changes to my billing details promptly to prevent any disruptions in claims processing and reimbursements.

Print Name | Signature | Date