UCLA Ronald Reagan Medical Center

AUTHENTICATION OF APPROVAL MS 104

Manual	Medical Staff	***Effective Date***	04/27/2006
Policy #	MS 104	***Date Revised***	12/31/2008
Responsible Person	Director, Medical Staff Administration	***Next Scheduled Review***	12/31/2020

PURPOSE

To ensure valid authentication of approval on all medical staff documents, including recommendation and approval forms as well as privilege delineation request forms.

POLICY

When an Officer of the Medical Staff or a Clinical Service Chief requests that a stamp or electronic version of their signature be made, that authentication will only be used at the instruction of the individual whose name it bears.

Those permitted to use these methods of authentication include:

1) Clinical Service Coordinators, who prepare supporting documentation for the Clinical Service Chief review.

2) Medical Staff Coordinators, who support the medical staff organization and its committees, and who use them with direct instruction from the signatory on correspondence prepared as a result of committee deliberations.

If a Clinical Service Chief determines that another senior member of their clinical service/division be authorized to sign on their behalf, the delegation will be formally made in accordance with the following procedure.

PROCEDURE

1) The signature stamp will be stored in a locked drawer and only utilized upon the instruction of the signatory.
2) When a stamp is no longer used, it is destroyed by removing the signature surface.
3) When a signature is scanned electronically, it will only be retained as long as that physician is serving as a signatory.
4) A listing with a signed statement of approval and or delegation will be maintained in Medical Staff Administration and updated for all signatories as they change (attached).

APPROVED

Medical Staff Executive Committee: 12/31/2008/reviewed w/no changes 12/31/2020
Governing Body: 12/31/2008/reviewed w/no changes 12/31/2020

DELEGATION OF AUTHORITY FOR SERVICE AND COMMITTEE REVIEW

CLINICAL SERVICE: _____

I hereby certify that the members of my Clinical Service whose names, titles and signatures appear below are authorized by me to sign on my behalf on all medical staff membership and privileging recommendations made for my clinical service:

_____	_____	_____
Signature	Printed Name	Date

_____
Title

Delegates

_____	_____	_____
Signature	Printed Name	Date

_____
Title

_____	_____	_____
Signature	Printed Name	Date

_____
Title

(Use additional pages if necessary)

SIGNATURE STAMP AUTHORIZATION

CLINICAL SERVICE: _____

I hereby approve the use of a signature stamp as a representation of my personal signature. I acknowledge responsibility for all documents bearing this authentication, and I attest to the fact that the authentication is at all times under my control.

_____ _____ _____

Signature Printed Name Date

_____

Title

SIGNATURE STAMP/ELECTRONIC AUTHORIZATION FOR OFFICERS

Signature stamp/Electronic Scanned Signature Authorization

I hereby authorize the use of my signature stamp/electronically scanned signature by Medical Staff Administration personnel under the supervision of the Director, Medical Staff Administration. This signature will be used for actions requiring my signature as a Medical Staff Officer in accordance with the activities identified in the Medical Staff Bylaws. These may include, but not be limited to, appointment and reappointment verification request forms, membership verification documents provided to requesting healthcare facilities and organizations, and endorsement of appointment and reappointment application forms.

This authentication will be maintained in a confidential locked drawer or privacy-protected electronic file, and used on my instructions. It shall be valid for the period _____ through _____.

_____	_____	_____
Chief of Staff	Printed Name	Date
_____	_____	_____
Vice Chief of Staff	Printed Name	Date
_____	_____	_____
Secretary	Printed Name	Date