



Employment Eligibility Verification
Department of Homeland Security
 U.S. Citizenship and Immigration Services

USCIS
Form I-9
 OMB No. 1615-0047
 Expires 10/31/2022

▶ **START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the first day of employment, but not before accepting a job offer.)*

Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>		Middle Initial	Other Last Names Used <i>(if any)</i>	
Address <i>(Street Number and Name)</i>			Apt. Number	City or Town		State ZIP Code
Date of Birth <i>(mm/dd/yyyy)</i>	U.S. Social Security Number □□□□ - □□ - □□□□		Employee's E-mail Address		Employee's Telephone Number	

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

<input type="checkbox"/> 1. A citizen of the United States	
<input type="checkbox"/> 2. A noncitizen national of the United States <i>(See instructions)</i>	
<input type="checkbox"/> 3. A lawful permanent resident (Alien Registration Number/USCIS Number): _____	
<input type="checkbox"/> 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): _____ Some aliens may write "N/A" in the expiration date field. <i>(See instructions)</i>	
<p><i>Aliens authorized to work must provide only one of the following document numbers to complete Form I-9: An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.</i></p> <p>1. Alien Registration Number/USCIS Number: _____ OR 2. Form I-94 Admission Number: _____ OR 3. Foreign Passport Number: _____ Country of Issuance: _____</p>	
QR Code - Section 1 Do Not Write In This Space	

Signature of Employee	Today's Date <i>(mm/dd/yyyy)</i>
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Preparer and/or Translator Certification (check one):
 I did not use a preparer or translator. A preparer(s) and/or translator(s) assisted the employee in completing Section 1.
(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Today's Date <i>(mm/dd/yyyy)</i>	
Last Name <i>(Family Name)</i>		First Name <i>(Given Name)</i>	
Address <i>(Street Number and Name)</i>		City or Town	State ZIP Code

Employer Completes Next Page



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Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents.")

Employee Info from Section 1	Last Name (Family Name)	First Name (Given Name)	M.I.	Citizenship/Immigration Status
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List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title		Document Title		Document Title
Issuing Authority		Issuing Authority		Issuing Authority
Document Number		Document Number		Document Number
Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)		Expiration Date (if any) (mm/dd/yyyy)
Document Title		Additional Information		QR Code - Sections 2 & 3 Do Not Write In This Space
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				
Document Title				
Issuing Authority				
Document Number				
Expiration Date (if any) (mm/dd/yyyy)				

Certification: I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment (mm/dd/yyyy): _____ **(See instructions for exemptions)**

Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	Title of Employer or Authorized Representative	
Last Name of Employer or Authorized Representative	First Name of Employer or Authorized Representative		Employer's Business or Organization Name	
Employer's Business or Organization Address (Street Number and Name)		City or Town	State	ZIP Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name (if applicable)			B. Date of Rehire (if applicable)	
Last Name (Family Name)	First Name (Given Name)	Middle Initial	Date (mm/dd/yyyy)	

C. If the employee's previous grant of employment authorization has expired, provide the information for the document or receipt that establishes continuing employment authorization in the space provided below.

Document Title	Document Number	Expiration Date (if any) (mm/dd/yyyy)
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I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	Name of Employer or Authorized Representative
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LISTS OF ACCEPTABLE DOCUMENTS

All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority <li style="text-align: center;">For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 		<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.



Corporate Integrity Program Policy

Home Department: Corporate Integrity Program

IMPORTANT NOTICE:

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I. POLICY STATEMENT

The Corporate Integrity Program is an integral part of the Cedars-Sinai organization and works to ensure that its employees understand and comply with applicable laws and policies and adhere to the highest standards of ethics and integrity. Each employee plays a vital role in achieving this goal.

II. APPLICABILITY

The Corporate Integrity Program applies to the following entities (collectively, "Cedars-Sinai"): Cedars-Sinai Medical Center, Marina del Rey Hospital, Cedars-Sinai Medical Care Foundation, and other affiliates as designated by Cedars-Sinai Health System from time to time.

III. POLICY

Corporate Integrity Program:

The Corporate Integrity Program has, at its foundation, seven elements that federal guidelines have deemed necessary for an effective, high-quality compliance program. The Program is intended to provide additional assurance that Cedars-Sinai:

- Complies in all material respects with federal, state, and local laws that are applicable to its operations
- Satisfies the conditions of participation in health care programs funded by the state and federal governments, the terms of its contractual arrangements, and applicable requirements and waivers associated with CMS requirements
- Detects and deters criminal conduct or other forms of misconduct by Cedars-Sinai employees
- Promotes self-monitoring and provides for, in appropriate circumstances, voluntary disclosure of violations of laws and regulations
- Establishes, monitors, and enforces high professional and ethical standards

The Corporate Integrity Program includes the following elements:

1. Written Policies and Procedures:

a. Standards of Conduct

Cedars-Sinai sets the standards and expectations for integrity and compliance through the Standards of Conduct. The Standards:

- Describe compliance expectations
- Provide guidance to employees and others on dealing with potential compliance issues
- Identify how to appropriately report compliance issues



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- Describe how potential compliance problems will be investigated and resolved

b. Compliance Policies and Procedures:

Cedars-Sinai has a comprehensive set of policies and procedures that addresses a wide range of compliance-related issues, including those addressing physician relationships, coding, specific billing and reimbursement topics, and compliance-related human resources policies. Compliance policies and procedures will be understandable to those for whom they are written and updated routinely as the underlying laws, regulations and guidance changes over time. Compliance policies will be made readily available and accessible to all employees via the Intranet site to ensure access to the organization's policies on compliance topics or risks.

2. Designation of a Compliance Officer and Compliance Committee:

a. Board of Directors, Corporate Integrity Committee Oversight

The Board of Directors of each Cedars-Sinai entity is responsible for assuring that the entity implements and maintains an effective corporate integrity program. The Corporate Integrity Committee of the Board of Directors oversees Cedars-Sinai's corporate integrity efforts, receives reports on a regular basis from Cedars-Sinai's President and Chief Executive Officer and/or Chief Compliance Officer concerning implementation and maintenance of the Program, and gives direction to management, as necessary or appropriate, to ensure that Cedars-Sinai conducts its activities in compliance with all applicable laws and the Standards, and advises the Board of Directors regarding the Program.

b. Chief Compliance Officer

Cedars-Sinai's Chief Compliance Officer (also known as the Vice President of Corporate Integrity) is responsible for the Program, and all its component parts, for Cedars-Sinai and all its affiliated entities (except where provided otherwise in the Program). The Chief Compliance Officer is a Cedars-Sinai executive with direct access to each Cedars-Sinai entity's President and Chief Executive Officer and the Chair of the Corporate Integrity Committee for purposes of reporting on corporate integrity issues and Program matters.

c. Operational Corporate Integrity Committee(s) and Executive Management

The Operational Corporate Integrity Committee(s) advise the Chief Compliance Officer and assist in the implementation of the Program. The Committee(s) will identify specific integrity risks selected for focused attention during each fiscal year, receive reports from and provide guidance to management staff whose responsibilities include the area in which the integrity risk exists.

In order to maximize efficiency and ensure local management ownership for the monitoring and management of corporate integrity-related risks, executive staff overseeing operations in which



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corporate integrity risks may arise are expected to create, maintain, and appropriately staff corporate integrity functions within their respective areas of responsibility.

3. Education and Training:

a. Initial Compliance Training

All new employees receive an initial compliance training session. The training session emphasizes Cedars-Sinai's commitment to compliance with all applicable laws. A statement acknowledging the employee's commitment to and receipt of the Standards of Conduct will be signed, dated, and maintained in the employee's file.

b. Annual Compliance Training

On an annual basis, all current employees are required to complete compliance training. This includes appropriate training regarding applicable state and federal regulations and guidelines, summarizing fraud and abuse statutes and regulations, coding requirements, claim submission processes, and employee conduct. Annual training is mandatory and may affect an employee's annual performance evaluation. Cedars-Sinai's compliance training will meet all applicable regulatory requirements in terms of timing, frequency, and content.

4. Effective Lines of Communication:

a. Access to the Chief Compliance Officer and Corporate Integrity Department

Cedars-Sinai recognizes that clear and open lines of communication between the Chief Compliance Officer and employees are important to the successful implementation of the Corporate Integrity Program. The Chief Compliance Officer and Corporate Integrity Department managers are available by appointment, telephone call, email, or by contacting the compliance hotline. To that end, confidentiality and non-retaliation policies and procedures will be maintained to encourage communication and the reporting of incidents of potential non-compliance with the Program.

b. Methods of Reporting

Cedars-Sinai maintains the following toll-free integrity hotline and address, so that employees have every opportunity to report concerns or possible wrongdoing regarding corporate integrity issues:

Hotline Telephone Number: 1-800-233-2775 (1-800-CEDARS5)
Address: Corporate Integrity Program
Cedars-Sinai
8700 Beverly Boulevard

**Corporate Integrity Program Policy****Home Department: Corporate Integrity Program****IMPORTANT NOTICE:****The official version of this document is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.**

Los Angeles, California 90048

Calls to the hotline and written communications will be treated confidentially, will not be traced, and may be provided anonymously. Cedars-Sinai will not retaliate against an employee for making a hotline call or written report regarding any integrity-related risk.

5. Enforcing Standards and Disciplinary Guidelines:**a. Sanction Screening Exclusion Checks**

Cedars-Sinai conducts appropriate background investigation, including a reference check, as part of every such employment application. Cedars-Sinai conducts ongoing monitoring of federal and state exclusion lists and does not employ individuals who have been convicted of a criminal offense related to health care, or who are listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federal health care programs.

b. Disciplinary Policies and Processes

Human Resources policies provide guidance for consistently applied and enforced discipline for non-compliant behavior. Disciplinary action taken regarding issues related to legal compliance will follow the currently established disciplinary process through the Human Resources Department.

6. Auditing and Monitoring:**a. Compliance Auditing**

In addition to the Cedars-Sinai Corporate Integrity Work Plan conducted by Internal Audit, the Program routinely undertakes monitoring and auditing efforts in support of Cedars-Sinai Standards, policies, and compliance activities. The Chief Compliance Officer may, from time to time, employ the services of outside advisors who have expertise in federal and state health care statutes, regulations and federal health care program requirements. Such audits are designed to address, among other possibilities, compliance with laws governing kickback arrangements, physician self-referrals, coding, claim development and submission, reimbursement, cost reporting, and research.

b. Monitoring

The Chief Compliance Officer will monitor the implementation and effectiveness of the Corporate Integrity program and will recommend updates to improve the Program based on internal and external changes. The Chief Compliance Officer will provide updates on any monitoring results to the Corporate Integrity Committee of the Board of Directors.

7. Responding to Detected Concerns and Corrective Action Initiatives:



Corporate Integrity Program Policy

Home Department: Corporate Integrity Program

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Cedars-Sinai investigates reported Compliance allegations and takes appropriate corrective action.

a. Investigations

All reports of compliance concerns will be investigated by the Corporate Integrity Department as appropriate to the nature of the concern. There may be instances where legal counsel is enlisted to oversee the investigation depending on the nature and severity of the events or processes involved.

b. Corrective Actions

When a compliance concern, or a risk for a possible compliance concern, is identified, corrective action will be taken to mitigate or eliminate the compliance risk from occurring or recurring. Appropriate actions may include the development of policies and procedures, providing education or awareness training, applying coaching, counseling or disciplinary action, improving processes, correcting errors, making refunds to government or private payers, etc.

c. Overpayments

Where compliance risks identify an overpayment to a government payer, such overpayments, once identified, will be returned to the applicable government entity within 60 days of the date of discovery.

Responsibilities of CS Employees:

Cedars-Sinai employees and physicians who care for our patients are expected to understand and comply with the laws and regulations governing their job activities and the ethical and legal standards set forth in the Corporate Integrity Program. Cedars-Sinai will provide a copy of the Corporate Integrity Program Policy and the Standards of Conduct to all employees at orientation, who will be required to sign an acknowledgement stating that they have received, reviewed, and understood the policy. who will be required to sign an acknowledgement stating that they have received, reviewed, and understood the policy.

Responsibilities of Management:

All levels of management have the primary responsibility to set Cedars-Sinai's standard for corporate integrity and compliance. Executives, Directors, and Managers ("Management" or "Managers") serve as the primary example, and an important source of information, for Cedars-Sinai employees. Management must communicate the importance of compliance to every employee and actively promote adherence to the Corporate Integrity Program. Informally, Managers must foster open

POLICY



CEDARS-SINAI

Original Effective Date: 07/01/2013
Last Modified Date: 01/25/2021

Corporate Integrity Program Policy

Home Department: Corporate Integrity Program

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communications about compliance and must direct all appropriate compliance-related questions raised by employees to the Corporate Integrity Office. Certain Managers will be called upon to give formal presentations to employees explaining the Corporate Integrity Program and instructing employees on how to deal with various compliance-related issues.

Management has an affirmative duty to fully understand the Corporate Integrity Program and the Standards of Conduct and to ask any and all questions to clarify their obligations and the obligations of those employees they manage. No Manager will be excused based on a claim of ignorance or good intentions. Managers who fail to comply with these obligations may be terminated or otherwise disciplined.

All Managers must ensure that all actual or potential compliance issues are reported to the Corporate Integrity Office. In addition, all Managers must be accessible to employees who wish to report compliance issues. Managers also have the responsibility to ensure that no employee is retaliated against, in any way, for reporting a compliance issue. Managers are equally accountable for their own actions, as well as the actions of the employees who they supervise.

IV. RELATED DOCUMENTS

Standards of Conduct

V. REFERENCES

70 Fed. Reg. 4858; January 31, 2005
63 Fed. Reg. 8987; February 23, 1998

VI. POLICY APPROVALS

Record of Approval Dates	
Original Effective Date	7/1/13
Committee Approvals	
Corporate Integrity Committee (formerly Audit Committee) of the Board of Directors	6/11/13; 12/1/20
Board of Directors	1/25/21



Title: **Housestaff Supervision Policy: Graduate Medical Education**

Home Department: **Academic Affairs/Graduate Medical Education**

IMPORTANT NOTICE:

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I. POLICY

- A. Supervision is to be readily available to residents/fellows on duty. Appropriate supervision is to be provided at all times, for all Physicians-In-Training, that ensures:
 - 1. Safe and effective patient care;
 - 2. each resident's/fellow's development of the skills, knowledge, and attitudes required to enter the unsupervised practice of medicine; and
 - 3. establishes a foundation for continued professional growth.
- B. In the clinical learning environment, each patient must have an identifiable, appropriately credentialed and privileged attending physician who is ultimately responsible for that patient's care.
 - 1. This information must be available to residents/fellows, faculty members, other members of the health care team, and patients.
 - 2. Residents/fellows and faculty members must inform each patient of their respective roles in that patient's care when providing direct patient care.
- C. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each physician-in-training must be assigned by the program director and faculty members.
 - 1. Faculty members functioning as supervising physicians should delegate portions of care to residents, based on the needs of the patient and the skills of the residents. Faculty supervision assignments should be of sufficient duration to assess the knowledge and skills of each resident/fellow and to delegate to the resident/fellow the appropriate level of patient care authority and responsibility.
 - 2. Senior residents or fellows should serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.
 - 3. Residents/fellows are to be supervised in such a way that they assume progressively increasing responsibility, including that for teaching and supervising junior residents and medical students, according to their level of training, ability and experience.
- D. Supervision may be exercised through a variety of methods, as appropriate to the situation. For many aspects of patient care, the supervising physician may be a more advanced resident or fellow. Other portions of care provided by the resident can be adequately supervised by the appropriate availability of the supervising faculty member, fellow or senior resident physician, either on site or by means of telecommunication technology. Some activities may require the physical presence of the supervising faculty

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member. In some circumstances, supervision may include post-hoc review of resident-delivered care with feedback.

1. To promote appropriate resident/fellow supervision while providing for graded authority and responsibility, programs must use the following classification of supervision.
 - a. Direct supervision:
 - i. the supervising physician is physically present (the teaching physician is located in the same room or partitioned/curtained area, if applicable, as the patient and/or performs a face-to-face service) with the resident/fellow during the key portions of the patient interaction; or
 - ii. the supervising physician and/or patient is not physically present with the resident/fellow and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.
 - iii. PGY-1 residents must initially be supervised directly as described in I.D.1.a.i above.
 - b. Indirect supervision: the supervising physician is not providing physical or concurrent visual or audio supervision but immediately available to the resident/fellow to provide appropriate direct supervision.
 - c. Oversight -- the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
2. The program must demonstrate that the appropriate level of supervision in place for all residents/fellows is based on their level of training and ability, as well as patient complexity and acuity.
3. The program must define when the physical presence of a supervising physician is required.
4. The program director must evaluate each resident's/fellow's abilities based on specific criteria, guided by the Milestones for the specialty.
5. Programs must set guidelines for circumstances and events in which residents must communicate with the supervising faculty member(s).
6. Each resident/fellow must know the limits of their scope of authority, and the circumstances under which the resident/fellow is permitted to act with conditional

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independence, i.e. graded, progressive responsibility for patient care with defined oversight.

- E. It is the responsibility of each Program Director to assure that there is a written program-level policy on supervision of program residents/fellows consistent with institutional policy and the respective ACGME Common and Specialty-/subspecialty-specific Program Requirements.
 - a. It is the responsibility of the Program Director to ensure that each member of the teaching staff is familiar with the program's written description of the roles, responsibilities and patient care activities expected of residents/fellows at each training level of the program (e.g., goals & objectives, curriculum), as well as criteria used to determine competency and promotion, to guide the teaching staff in determining the appropriate level of responsibility for individual program physicians-in-training.
- 1. Level of responsibility for teaching and supervising junior residents and medical students:
 - a. Determination of a resident's/fellow's readiness for teaching and supervising junior residents and medical students is to be made by the Program Director or his/her designee.
 - b. It is the responsibility of each Program Director to ensure that a written policy exists for the program or department that provides guidance for determining a resident's readiness to assume responsibility for teaching and supervising junior residents and medical students.
 - c. The Program Director shall ensure that all members of the program's teaching staff review and are familiar with the written policy and are informed of the program residents' current level of responsibility with regard to teaching.
- 2. Level of Responsibility for Patient Care Documentation:
 - a. It is expected that residents/fellows will place orders for patients under their care, with appropriate supervision by the attending physician. This in no way interferes with the right of the members of the medical staff to place orders for their patients who are seen by residents/fellows, however, it is expected that such occurrences will be infrequent, and that the attending physician will communicate his or her action to the resident in a timely manner.
 - b. Residents/fellows may make Medical Record entries without direct supervision. Counter-signature, as appropriate, is the responsibility of the patient's attending physician.

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- c. Residents/fellows may enter into the medical record admitting and consultation notes (including History and Physical) for patients as per departmental policies. Residents/fellows must contact the responsible member of the medical staff (attending physician). The attending physician will then see the patient, evaluate the patient, and document the evaluation with a note, to be placed within 24 hours of the patient's admission or sooner if clinically indicated as per medical staff rules and regulations.
 - d. Resident's/fellow's progress notes will be regularly reviewed by the attending physician, after the attending physician has evaluated the patient and documented his/her patient evaluation in the medical record.
 - e. Violations of the supervision policy will be communicated, as soon as they become evident, to the Program Director and to the Department Chair and/or Clinical Chief to assure that the patient is seen appropriately by an attending physician.
3. Rotators into CSMC may be subject to more stringent supervision rules if their program's policies so state.
- F. Outpatient activities:
- New patients seen in outpatient clinics should be seen by, or discussed with, the responsible member of the medical staff at the initial visit. This is to be documented in the patient medical record, either by the member of the medical staff, or by the resident/fellow with a summary of the discussion. Return patients should be seen by, or discussed with, the responsible member of the medical staff at such a frequency to ensure that the course of treatment is effective and appropriate. This will be documented in the medical record by the resident/fellow or by the member of the medical staff.
- G. Physician-in-training Patient Care Activity Approvals:
1. All training programs shall maintain a current listing of the program's residents/fellows in New Innovations, indicating which patient care activities each individual is approved to perform without direct supervision.
 2. It is the responsibility of the Program Director to determine by what criteria a resident/fellow qualifies for approval to perform a given patient care activity.
 3. The listing of each resident's/fellow's approvals shall be made available to all Medical Center patient care staff and administrators.
 4. If the listing does not show a resident/fellow as approved for a given activity, that resident/fellow may perform the activity if either:

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- a. The resident/fellow can present an "approvals" notice signed by his/her program director (or designee) indicating he/she is qualified to perform the activity without direct supervision; OR
 - b. The resident/fellow is supervised by another resident/fellow, or physician who is approved to perform the activity without direct supervision.
5. The Program Director shall ensure that all program residents/fellows are informed of the need for approval to perform certain activities without direct supervision. If a resident/fellow knowingly performs a given activity without appropriate approval (or as given in F.4. above), he/she shall be counseled by his/her program director and may be subject to disciplinary action (see GME Policy "Grievance and Due Process").
- H. Supervision of residents in the Emergency Department.
1. If there is a disagreement about the disposition or management of a patient being seen in the Emergency Department between a resident/fellow and the ED Attending physician, then the discussion must be carried along the chain-of-command.
 2. The Emergency Department attending physician may, depending on the clinical situation, request that the attending physician on-call (who is providing oversight to the resident/fellow within the department) be physically present to evaluate the patient.
- I. Oversight and Communication:
1. Oversight of adherence to this policy is the responsibility of the Graduate Medical Education Committee (GMEC).
 2. Performance Improvement (PI) and Quality Assurance (QA) Committees are expected to identify problems resulting from inadequate supervision and to report these problems to the appropriate program director and the Associate Dean, Medical Education. The Associate Dean, Medical Education shall report to the GMEC on issues brought to him/her by the PI and QA Committees. Additionally, residents/fellows may report inadequate supervision in a protected manner free from reprisal using the CS-Safe (Incident Reporting System).
 3. The Chair of the GMEC shall periodically communicate with the Medical Executive Committee (MEC), via communication with the Senior Vice President for Academic Affairs, about the educational needs and performance of the residents/fellows.
 4. The Chair of the GMEC shall ensure that feedback from the MEC, as well as other communication that impacts resident/fellow activities, is communicated to the Program Directors.

Title: Housestaff Supervision Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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5. Each training program will have a program-specific policy further detailing responsibilities for the supervision of residents/fellows. Specifically, the departmental policies will include the criteria for approval to perform procedures without direct supervision, a list of procedures which require approval to so perform, a program-specific chain of command document, guidelines for circumstances and events in which residents/fellows must communicate with appropriate supervising faculty members (such as the transfer of a patient to an intensive care unit, or end-of-life decisions), and a brief descriptions of the roles, responsibilities, and patient care activities expected of residents/fellows at each year of training for the program.
6. Each training program will develop and distribute on-call schedules for teaching staff that ensure that qualified supervising faculty will be continuously and immediately available to any resident/fellow who is on duty or on call, and that a means for rapid communication with that faculty member will be made available to the resident/fellow.

II. PURPOSE

- A. To ensure that residents/fellows are provided with a level of supervision that encourages their professional growth without diminishing patient care quality, in accordance with requirements of the Accreditation Council for Graduate Medical Education (ACGME).
- B. To ensure that responsibility for the supervision of residents/fellows is clearly delineated, and that a resident's/fellow's level of responsibility can be readily determined by patient care providers and administrators within the Medical Center, in accordance with the requirements of The Joint Commission.
- C. To ensure that each resident/fellow knows the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.
- D. To ensure that effective communication occurs between the GMEC and the MEC regarding quality of patient care, educational needs and other issues as they relate to residents/fellows.

III. RESPONSIBILITIES

- A. Although it is expected that as residents/fellows proceed through a training program, the patient care responsibilities assigned to them will reflect their professional growth, the Medical Center must bear the ultimate responsibility for assuring the delivery of quality patient care in all teaching programs. The attending physician has ultimate responsibility for the care of the patient.
- B. Program directors are responsible for the establishment of departmental or programmatic policies to ensure that all residents/fellows are adequately supervised in their treatment of patients. These policies should provide:

Title: Housestaff Supervision Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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1. Written descriptions of supervisory lines of responsibility for the care of patients (i.e., "chain of command");
2. Procedures to ensure a patient's continuity of care and effective transitions of care;
3. Structure of on-call scheduling such that supervision is readily available to residents/fellows on duty.
4. Prompt, reliable systems for communicating with supervisory physicians either in emergency situations or in situations where a resident/fellow has questions or concerns about the appropriate treatment of a patient;
5. Obligation of residents/fellows to communicate with attending staff on a regular basis regarding the progress of their patients; and
6. Appropriate levels of staffing so that at no time is there excessive reliance on residents/fellows to fulfill service obligations.
7. Brief statements regarding the roles, responsibilities and patient care activities of residents/fellows by PGY, and relevant competency/advancement criteria (see GME Policy "Promotion & Non-renewal Of Physician-In-Training Agreement").

IV. PROCEDURES

- A. The GMEC shall oversee adherence to the Supervision Policy via periodic review of program-level policies.
- B. Physician-in-training Approvals:
 1. Program directors determine, based on departmental criteria, who qualifies for approval for given patient care activities.
 2. Programs enter the approvals determined by the program director in the Logger module of New Innovations at the "Independent" privilege level or configure the module to confer this level after a set number of approved performances of the procedure.
 3. In unusual situations when approvals are granted in between updates to New Innovations, program directors shall issue to newly approved residents/fellows a signed notice indicating which approval(s) have been granted.
 4. For rotators who are at CSMC for one month or less, program directors shall issue a signed notice of approvals or include the individual's approvals in New Innovations. For rotators who are at CSMC for more than one month, program directors shall include the individual's approvals in New Innovations.

V. POLICY APPROVAL(S)

Graduate Medical Education Committee: August 31, 2021

Policy



Effective Date: 09/21/2021

Title: Housestaff Supervision Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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Mark S. Noah, MD
Designated Institutional Official
Associate Dean, Medical Education

Original Effective Date: 07/01/2011

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POLICY

Title: Equal Employment Opportunity Policy

Home Department: Human Resources/Organization Development

Effective Date: January 1, 2021

Last Review Date: November 4, 2020

IMPORTANT NOTICE:

The official version of this document is contained in the HR Service Center website and may have been revised since the document was printed.

I. Scope

This policy applies to all employer agents and employees of Cedars-Sinai Medical Center and Cedars-Sinai Medical Care Foundation (referred to as "Cedars-Sinai"), including, but not limited to, non-supervisory personnel, trainees, supervisors, managers, directors, faculty, executives, and other key personnel. Cedars-Sinai is also committed to protecting its applicants, volunteers, unpaid interns and independent contractors from unlawful harassment.

II. Policy Statement(s)

Equal Employment Opportunity is the right of all persons to work and advance on the basis of performance, education, experience and skill. Cedars-Sinai believes in and is committed to providing Equal Employment Opportunity and a work environment free of unlawful

discrimination and harassment, as defined by federal and state law. Any violations of this policy will be treated as serious misconduct and result in appropriate corrective action, which may include termination of employment.

It is the responsibility of every employee to comply with this policy. Reports of unlawful conduct, including such conduct between co-workers, by third parties (e.g. vendors), and by managers and supervisors, will be investigated and addressed accordingly as outlined below.

Managers and supervisors who make decisions about hiring, training, performance evaluations, promotions, and work assignments are responsible for implementing and enforcing this policy as an integral part of personnel management.

III. Purpose

The purpose of this policy is to establish rules for and provide guidance regarding Cedars-Sinai's commitment to equal employment opportunity and to inform employees about how to raise such issues.

IV. Definitions of Key Terms and Concepts

Term / Concept	Definition
Harassment	When an unpleasant situation is created for someone, especially persistent, offensive, uninvited and unwelcome verbal or physical conduct.
Reasonable Accommodation	Reasonable changes in the application process or work environment that allow individuals with disabilities to have an equal opportunity to be considered for a job and to perform the essential functions of the job.
Undue Hardship	Undue hardship is determined on a case-by-case basis and may include considerations such as feasibility and significant risk to health and safety of the individual or others, including the impact on patient care/safety.
Unlawful Harassment	Harassment becomes unlawful where enduring the offensive conduct becomes a condition of continued employment, or the conduct is severe or pervasive enough to create a work environment that a reasonable person would consider intimidating, hostile or abusive.



Term / Concept	Definition
Victim	<p>An individual who is the victim of:</p> <ul style="list-style-type: none"> • Domestic violence; • Sexual assault; • Stalking; • A crime which caused physical injury; or • A crime which caused mental injury and threat of physical injury <p>Also includes an employee whose immediate family member deceased as the direct result of a crime.</p>

V. Policy Applicability and Requirements

Employees covered by a collective bargaining agreement (“CBA”) should refer to their CBA. In the event of a conflict between this policy and the CBA, the CBA controls.

Reasonable Accommodation

Cedars-Sinai provides reasonable accommodation(s) for:

- Qualified individuals with mental and/or physical disabilities whose needs are made known, provided the accommodation does not cause undue hardship, such as, but not limited to, potentially compromising patient care or safety
- Individuals whose needs regarding religious observances or practices are made known, provided the accommodation does not cause undue hardship, such as, but not limited to, potentially compromising patient care or safety, and
- Individuals who are victims as defined above whose needs are made known, provided the accommodation does not cause undue hardship, such as, but not limited to, potentially compromising patient care or safety.

An employee seeking an accommodation should notify their supervisor as soon as the need for an accommodation is known or is practicable. In some cases, steps may be taken towards evaluating an oral request, but a written request must follow. If the supervisor is unable to resolve the situation, the employee should contact the next person in the department’s chain of command. In the alternative, the employee may provide the written notice to the department’s assigned Human Resource Business Partner (HRBP) or designee.

Unlawful Harassment

Cedars-Sinai maintains a strict policy prohibiting unlawful harassment of any kind, including harassment on the basis of race (includes hair texture and protective hairstyles such as braids, locks, twists, etc.), religious creed (includes religious dress and grooming practices), color, national origin (includes language use and possession of driver's license issued to persons unable to prove their presence in the United States is authorized under federal law),



citizenship, ancestry, physical or mental disability (including HIV and AIDS), legally protected medical condition (cancer-related or genetic characteristics or any genetic information), requesting and/or taking Family Care and Medical Leave, marital status, sex, sexual orientation, gender, gender identity, gender expression, pregnancy (includes childbirth, breastfeeding and medical conditions related to pregnancy childbirth, breastfeeding), age (40 or older), military status, veteran status, criminal background or any other basis protected by federal state and/or local law. Such unlawful harassment based upon a protected characteristic includes unwelcome verbal, non-verbal, physical, or visual conduct that creates an intimidating, offensive, or hostile working environment or that unreasonably interferes with work performance.

Sexual Harassment

Unwelcome sexual advances, requests for sexual favors, and other verbal, physical or visual conduct of a sexual nature constitute unlawful sexual harassment where: (1) submission to such conduct is made either an explicit or implicit condition of employment; (2) submission to or rejection of the conduct is used as the basis for an employment decision; or (3) the conduct has the purpose or effect of unreasonably interfering with work performance or creating an intimidating, hostile, or offensive work environment.

Unlawful Discrimination

Cedars-Sinai does not unlawfully discriminate on the basis of race (includes hair texture and protective hairstyles such as braids, locks, twists, etc.), religious creed (includes religious dress and grooming practices), color, national origin (includes language use and possession of driver's license issued to persons unable to prove their presence in the United States is authorized under federal law), citizenship, ancestry, physical or mental disability (including HIV and AIDS), legally protected medical condition (cancer-related or genetic characteristics or any genetic information), requesting and/or taking Family Care and Medical Leave, marital status, sex, sexual orientation, gender, gender identity (Including transgender and transitional gender), gender expression, pregnancy (includes childbirth, breastfeeding and medical conditions related to pregnancy childbirth or breastfeeding), age (40 or older), military status, veteran status, criminal background or any other basis protected by federal state and local law. All personnel decisions are to be administered in accordance with this policy and in compliance with applicable federal state and local law, including, but not limited to, decisions regarding recruitment, selection, training, promotion, compensation, benefits, transfers, lay-offs, tuition assistance, and social and recreational programs.

Complaint Procedure

Cedars-Sinai encourages all employees to immediately report any conduct prohibited by this policy so that complaints can be quickly and fairly investigated and resolved. The term "report" as used in this policy is the employee's account of the incident(s) that occurred. The report need not be made in writing, but should, in any case contain all relevant details, including:

- the facts of the incident(s)
- the names of the individuals involved



- the names of any witnesses to the incident(s)

Although a written report is not required, one may be requested and often proves useful to provide clarity and avoid confusion as to the substance and nature of the complained-of conduct.

To ensure that Cedars-Sinai is able to fairly and quickly address any actual or perceived violation of this policy, the following reporting procedures are to be followed by any employee who believes that he or she has been subjected to conduct in violation of this policy or who believes that he or she has witnessed conduct in violation of this policy by any supervisor, employee, agent, vendor, independent contractor, patient, or visitor to Cedars-Sinai:

- Immediately tell the person that his or her behavior or actions are considered inappropriate and unwelcome and request that the conduct stop. Persons so told should comply promptly and graciously with such requests.
- In the event that direct verbal communication with the person does not resolve the issue or the employee feels uncomfortable communicating directly with the person, the employee should report the details of the incident(s) to his or her immediate supervisor (or, in the alternative, to the department's assigned HR Business Partner (HRBP) or Human Resources Practice Manager (HRPM), as explained below). Any supervisor who becomes aware of or receives a complaint involving a possible violation of this policy should contact their HRBP, HR Manager or designee as soon as possible, but in no event later than close of the next business day, to report the possible violation.
- If, after making a report to his or her immediate supervisor, an employee continues to believe that he or she has been subjected to conduct in violation of this policy or feels that his or her concerns were not adequately addressed, the employee should report the details of the incident(s) to the next person in the department's chain of command. When possible, the employee should provide a copy of the original written report, if one was prepared. If the employee remains dissatisfied following this second report, the employee should report the details of the incident(s) directly to the Director or Vice President of the department. If possible, the employee should provide a copy of any previous written reports.
- An employee may, at any time, bypass one or all of the foregoing steps and report the incident(s) directly to the department's HRBP or designee. If the employee feels that his or her concerns were not adequately addressed by the HRBP, the employee should report the incident(s) to the HR Manager or HR Director.
- An employee may anonymously report the incident(s) via the confidential Human Resources Phone line at 310-423-3464. Anonymous reports will be investigated to the full extent possible, based on the information provided by the employee.

A fact-finding investigation, either conducted by or under the direction of Human Resources, will be promptly undertaken upon receipt of a report of an alleged violation of this policy. Cooperation is expected from all employees during the fact-finding process. The findings will be reported to management personnel with authority to draw conclusions and direct corrective action, in accordance with Cedar-Sinai's Corrective Action and other applicable policies. Appropriate corrective action, which may include termination, will be taken against any person who has been found to have violated this policy.



Cedars-Sinai understands that reporting the types of behaviors prohibited by this policy may be difficult, and that an employee may hesitate to come forward. Therefore, we will handle investigations with sensitivity and maintain confidentiality to the extent possible.

Retaliation Prohibited

Retaliation by any person covered by this policy (including co-workers and third parties) against any person who, in good faith, reports a violation of this policy or participates in a fact-finding investigation is strictly prohibited. Retaliation is a very serious violation of this policy and should be reported immediately to the department's HRBP, HR Manager, HR Director, or designee. Individuals who engage in retaliation will be subject to corrective action, which may include termination of employment.

VI. Policy Exceptions

There are no exceptions to this policy allowed.

VII. Related Policies

- [Accommodating Disabilities Policy](#)
- [Dress and Personal Appearance Policy](#)
- [Sick Pay Policy](#)
- [Sick Pay Policy, Medical Network](#)
- [Sick Pay Policy, Medical Network - City of Santa Monica](#)
- [Time Off for Civic Responsibilities and Domestic Matters Policy](#)

VIII. Related Forms and Resources

- Rights of Victims of Domestic Violence, Sexual Assault and Stalking
- Confidential Human Resources Phonenumber: 310-423-3464 (Extension 3-3464)

IX. References

Harassment, Discrimination & Inappropriate Conduct

X. Questions

For questions about this or any HR policy, please call myHR at 1-833-CS4-MYHR (1-833-274-6947) or extension 4-MYHR (4-6947).

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Home Department: Academic Affairs / Administration

Document Owner: Nicole Leonard (Vice President)

IMPORTANT NOTICE:

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I. POLICY

Cedars-Sinai Medical Center (CSMC) is committed to maintaining the scientific integrity, independence and scholarship of its research and educational programs and to preserving the public trust in research. CSMC's academic and clinical policies, standards, ethics training and Research Misconduct Policy reflect its commitment to scientific integrity. CSMC considers Research Misconduct to be a serious departure from the professional standards expected of all CSMC Members and an ethical violation, which may, in certain cases, require the cessation of the research or educational program at issue, reporting to institutional or governmental oversight bodies and/or disciplinary action.

This Policy: (a) establishes CSMC's procedure for conducting Research Misconduct Proceedings; (b) provides for appropriate anti-retaliation and confidentiality protections for all individuals involved in the process; and (c) identifies and addresses additional institutional obligations under Applicable Law for reporting and monitoring Research Misconduct.

II. DEFINITIONS

- A. Capitalized Terms. Capitalized terms shall be given the meaning set forth in this Article II for purposes of this Policy. Non-capitalized terms shall be given their everyday meaning.
1. "Academic Affiliation Agreement" means the applicable Affiliation Agreement by and between CSMC and any institution where the Respondent holds a faculty appointment, including but not limited to that certain Affiliation Agreement by and between The Regents of the University of California on behalf of the University of California, David Geffen School of Medicine at UCLA ("UCLA") and CSMC, dated August 26, 2004.
 2. "Allegation" means a disclosure of possible Research Misconduct through any means of communication.
 3. "Applicable Law" means the regulatory requirements, principles and standards set forth and espoused in 42 C.F.R. Part 93 and its enabling statute.
 4. "Assessment" means the initial review of an Allegation by the applicable Department Chair, in consultation with the Research Integrity Officer, to determine whether (a) the Allegation is sufficiently credible and specific so that

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potential evidence of Research Misconduct can be identified; (b) the Allegation relates to Research Misconduct as opposed to other forms of non-compliance; (c) the Research Misconduct concerns a research activity governed by Section 93.102 of Applicable Law; and (d) based on these conclusions, an Inquiry is warranted.

5. "Cedars-Sinai Medical Center" or "CSMC" means Cedars-Sinai Medical Center and its affiliates including any hospital, health care, research, clinical, administrative, and instructional facility, including any center, department, institute and unit therein or affiliated therewith, owned or leased by, or gifted to, Cedars-Sinai Medical Center, and any other locations (a) used by a CSMC Member within the scope of his or her employment, in the performance of his or her responsibilities to CSMC, or in the furtherance of CSMC business; or (b) used by a CSMC visitor or student within the scope of his or her assigned responsibilities to CSMC; including all services, personnel, equipment, supplies and other contributions or resources offered by, and programs sponsored by, any of the foregoing; "affiliate" for the purposes of this definition means any entity that controls, is controlled by, or is under common control with Cedars-Sinai Medical Center.
6. "Complainant" means a person who in Good Faith makes an Allegation of Research Misconduct.
7. "CSMC Member" or "Members" means a person who is employed by, is an agent of, or is affiliated by contract or agreement with CSMC. CSMC Members include officials, tenured and untenured faculty, teaching and support staff, researchers, research coordinators, clinical technicians, postdoctoral and other fellows, students, volunteers, agents, and contractors, subcontractors, sub-awardees and any employees thereof.
8. "Deciding Official" means the Senior Vice President for Academic Affairs and Dean of the Medical Faculty, or the institutional official designated by the Senior Vice President for Academic Affairs and Dean of the Medical Faculty to serve as the Deciding Official. The Deciding Official is responsible for making final determinations regarding Allegations, Inquiries and any sanctions to be imposed where the Investigation Committee has made a finding of Research Misconduct, and may have peripheral, but not direct, prior involvement in any Inquiry, Investigation or Assessment.

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9. "Department Chair" means the chair of the applicable CSMC department or the director of the applicable CSMC institute, as appropriate.
10. "Departmental Appeals Board" means, depending on the context, (a) the organization, within the Office of the Secretary, established to conduct hearings and provide impartial review of disputed decisions made by HHS operating components; or (b) an Administrative Law Judge at the Departmental Appeals Board.
11. "Evidence" means any document, tangible item, or testimony offered or obtained during a Research Misconduct Proceeding that tends to prove or disprove the existence of an alleged fact.
12. "Fabrication" means making up data or results and recording or reporting them.
13. "Falsification" means manipulating research materials, equipment, or processes, or changing or omitting data or results such that the research is not accurately represented in the Research Record.
14. "Good Faith" as applied to a Complainant or witness, means having a belief in the truth of one's Allegation or testimony that a reasonable person in the Complainant's or witness's position could have based on the information known to the Complainant or witness at the time. An Allegation or cooperation with a Research Misconduct Proceeding is not in Good Faith if made with knowing or reckless disregard for information that would negate the Allegation or testimony.
15. "HHS" means the United States Department of Health and Human Services.
16. "Inquiry" means the preliminary information-gathering and preliminary fact-finding necessary to determine whether an Investigation is warranted.
17. "Inquiry Committee" means the CSMC committee charged with conducting the Inquiry and creating the Inquiry Report.
18. "Inquiry Report" means the report generated by the Inquiry Committee.
19. "Investigation" means the formal development of a factual record and the examination of that record leading to a recommendation as to whether

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Research Misconduct occurred and other appropriate actions, including administrative actions.

20. "Investigation Committee" means the CSMC committee charged with conducting the Investigation and creating the Investigation Report.
21. "Investigation Committee Chair" means the individual designated by the Senior Vice President for Academic Affairs and Dean of the Medical Faculty to serve as chair of the Investigation Committee.
22. "Investigation Report" means the report generated by the Investigation Committee.
23. "Office of Research Integrity" or "ORI" means the office to which the HHS Secretary has delegated responsibility for addressing research integrity and misconduct issues related to PHS Supported activities.
24. "Public Health Service" or "PHS" means the unit within HHS that includes the Office of Public Health and Science and the following Operating Divisions: Agency for Healthcare Research and Quality, Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, Food and Drug Administration, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Substance Abuse and Mental Health Services Administration and the offices of the Regional Health Administrators.
25. "PHS Support" means PHS funding, or applications or proposals therefor, for biomedical or behavioral research, biomedical or behavioral research training, or activities related to that research or training, that may be provided through: Funding for PHS intramural research; PHS grants, cooperative agreements, or contracts, subgrants or subcontracts under such PHS funding instruments; or salary or other payments under PHS grants, cooperative agreements or contracts.
26. "Plagiarism" means the appropriation of another person's ideas, processes, results or words without giving appropriate credit.
27. "Policy" means this Research Misconduct Policy.

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28. "Research Integrity Officer" means the institutional official designated by the Senior Vice President for Academic Affairs and Dean of the Medical Faculty to serve as the Research Integrity Officer. The Research Integrity Officer is responsible for assisting with Allegations, Inquiries and Investigations, in addition to the other responsibilities described in this Policy.
29. "Research Misconduct" means Fabrication, Falsification or Plagiarism in proposing, performing or reviewing research or in reporting research results. Research Misconduct does not include honest error or differences of opinion.
30. "Research Misconduct Proceeding" means any actions related to alleged Research Misconduct, including but not limited to, Assessment, Inquiry, Investigation, ORI oversight review, hearings and administrative appeals.
31. "Research Record" means the record of data or results that embody the facts resulting from scientific inquiry, including, but not limited to, research proposals, laboratory records both physical and electronic, progress reports, abstracts, theses, oral presentations, internal reports, journal articles and any documents and materials provided to HHS or to the Research Integrity Officer by a Respondent in the course of a Research Misconduct Proceeding.
32. "Respondent" means the person who is the subject of a Research Misconduct Proceeding.
33. "Scientific Integrity Committee" or "SIC" means the CSMC Scientific Integrity Committee.
34. "SIC Chair" means the individual designated by the Senior Vice President for Academic Affairs and Dean of the Medical Faculty to serve as chair of the Scientific Integrity Committee.

III. GENERAL PRINCIPLES

- A. General CSMC Obligations. Applicable Law requires entities who request and receive PHS Support to:
 1. Have written policies and procedures for addressing Allegations;

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2. Respond to each Allegation in a thorough, competent, objective and fair manner, including precautions to ensure that individuals responsible for carrying out any part of the Research Misconduct Proceeding do not have any biases or unresolved personal, professional or financial conflicts of interest with the Complainant, the Respondent or witnesses;
 3. Foster a research environment that promotes the responsible conduct of research, research training, and activities related to that research or research training, discourages Research Misconduct, and deals promptly with Allegations or Evidence of possible Research Misconduct;
 4. Take all reasonable and practical steps to protect the positions and reputations of Complainants, witnesses and committee members and protect them from retaliation by Respondents and other institutional members;
 5. Take all reasonable and practical steps to protect the confidentiality of Respondents, Complainants and all participants in a Research Misconduct Proceeding as further described in [Section III.G](#);
 6. Comply with all state and federal law regarding the preservation of confidentiality of research subjects and patients;
 7. Take all reasonable and practical steps to ensure the cooperation of Respondents and other institutional members with Research Misconduct Proceedings, including, but not limited to, their providing information, Research Records and Evidence;
 8. Cooperate with HHS during any Research Misconduct Proceeding or compliance review;
 9. Assist in administering and enforcing any HHS administrative actions imposed on its institutional members; and
 10. Have an active assurance of compliance.
- B. Applicability. This Policy applies to all CSMC Members. In furtherance of CSMC's commitment to research integrity, this Policy applies to all Research Misconduct Proceedings, regardless of whether the research activity was supported in whole or in part by PHS Support. Therefore, this Policy applies to:

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1. Research activities funded by PHS Support for which CSMC is the grantee, or otherwise receives, administers or disburses the PHS Support;
 2. Research activities funded by PHS Support, where a CSMC Member who is engaged in the performance of services or responsibilities at or for CSMC in connection with the research activities is the grantee, or otherwise receives, administers or disburses grant funds;
 3. Research activities funded by PHS Support, where the activity is conducted principally at CSMC facilities and CSMC's costs are covered in whole or in part by PHS Support; or
 4. Research not funded by PHS Support, but the Respondent is a CSMC Member who is engaged in the performances of services or responsibilities at or for CSMC; provided, however, that the ORI reporting obligations described in this Policy (other than those set forth in Section III.J) shall not attach in the event that the Allegation concerns a research activity that falls under this Section III.B.4.
 5. The ORI reporting obligations described in this Policy shall attach in the event that the Allegation concerns a research activity that falls under Section III.B.1, III.B.2 or III.B.3.
 6. In general, this Policy is not intended to apply to conduct that deviates from laws promulgated to protect the safety and well-being of subjects, animals, or the laboratory work environment.
- C. Standard of Proof. A CSMC finding of Research Misconduct must be proven by a preponderance of the Evidence. This means that the totality of the evidence must show that it is more likely than not that the Respondent committed Research Misconduct. To make a finding of Research Misconduct, (a) the Respondent's actions must have represented a significant departure from accepted practices of the relevant research community; and (b) the Research Misconduct must have been committed intentionally, knowingly or recklessly.

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- D. Burden of Proof.
1. CSMC has the burden of proof for making a finding of Research Misconduct.
 2. The destruction or absence of, or the Respondent's failure to provide, Research Records adequately documenting the questioned research is evidence of Research Misconduct where CSMC establishes by a preponderance of the evidence that the Respondent intentionally, knowingly or recklessly had Research Records and destroyed them, had the opportunity to maintain such records and failed to do so, or maintained the records and failed to produce them in a timely manner, and that the Respondent's conduct constitutes a significant departure from accepted practices of the relevant research community.
 3. The Respondent has the burden of proving, by a preponderance of the evidence, any and all affirmative defenses raised, proof of honest error or differences of opinion, and any mitigating factors relevant to a decision to impose administrative actions, sanctions or discipline following a Research Misconduct Proceeding.
 4. CSMC must consider any admissible, credible Evidence submitted by the Respondent to prove honest error or difference in opinion in determining whether CSMC (or HHS) has met its burden of proof that the alleged Research Misconduct was intentional, knowing or reckless.
- E. Responsibility to Cooperate. Each CSMC Member has an obligation to report conduct that he or she believes, in Good Faith, may constitute Research Misconduct. If a CSMC Member has questions regarding whether conduct constitutes Research Misconduct, or regarding the obligations of CSMC Members under this Policy to report instances of Research Misconduct, the CSMC Member should speak to his or her supervisor or the applicable Department Chair or contact the Research Integrity Officer. All CSMC Members, regardless of whether they are active participants in research, are expected to fully cooperate with any Research Misconduct Proceeding. All CSMC Members have an obligation to candidly respond to questions and to provide relevant Evidence when requested to do so.
- F. Retaliation. CSMC will not tolerate retaliation against any individual participating in or cooperating with a Research Misconduct Proceeding. If any CSMC Member retaliates

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against an individual for his or her role in a Research Misconduct Proceeding, that CSMC Member will face disciplinary action.

- G. Confidentiality. The Complainant(s), the Respondent(s) and CSMC Members involved in a Research Misconduct Proceeding, and experts and witnesses, will execute a *Confidentiality Acknowledgement* (see the attached sample form) to maintain the confidentiality of any proceedings and the content of any information or documents. Notwithstanding the foregoing, CSMC cannot guarantee the anonymity of the Complainant, the Respondent, or other participants in the Research Misconduct Proceeding, in light of CSMC's need to record and report evidence and of the Respondent's rights to reasonable and sufficient information to defend himself or herself against the Allegation. Disclosure of the identity of the Respondent(s), Complainant(s), witnesses and other participants will be limited, to the extent possible, to those who need to know, consistent with a thorough, competent, objective and fair proceeding and Applicable Law. The Research Integrity Officer is responsible for ensuring that confidentiality is provided to all individuals involved in the Research Misconduct Proceeding in accordance with this Policy.
- H. Record Retention. Unless custody has been transferred to HHS or ORI has advised CSMC in writing that it no longer needs to retain the records, CSMC will maintain records of the Research Misconduct Proceeding in a secure manner for seven (7) years after completion of the Proceeding or completion of any PHS proceeding involving the Research Misconduct Allegation, whichever is later.
- I. Early Termination of a Research Misconduct Proceeding.
1. If ORI reporting obligations attach pursuant to Section III.B, CSMC must notify ORI in advance and obtain ORI's permission if it wishes to close a Research Misconduct Proceeding on grounds that (a) the Respondent has admitted guilt; (b) a settlement has been reached with the Respondent; or (c) for any other reason; provided, however, that CSMC is not required to notify ORI or obtain ORI's permission to close a Research Misconduct Proceeding on the following grounds: (i) ORI did not initiate the Inquiry and it is found during the Inquiry stage that an Investigation is not warranted; or (ii) it is found during the Investigation stage that no Research Misconduct has occurred.
 2. The termination of a Respondent's employment or affiliation with CSMC, by resignation or otherwise, before or after an Allegation of Research Misconduct

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has been reported, will not preclude or terminate CSMC's Research Misconduct procedures. A Respondent may not elect to resign his or her positions with CSMC in exchange for CSMC's termination of an Inquiry or Investigation.

- J. Immediate Notice to ORI. The Research Integrity Officer will notify ORI immediately if there is reason to believe that any of the following conditions exist during any stage of the Research Misconduct Proceeding:
1. Health or safety of the public is at risk, including an immediate need to protect human or animal subjects;
 2. HHS resources or interests are threatened;
 3. Research activities should be suspended;
 4. There is a reasonable indication of possible violations of civil or criminal law;
 5. Federal action is required to protect the interests of those involved in the Research Misconduct Proceeding;
 6. CSMC believes the Research Misconduct Proceeding may be made public prematurely so that HHS may take appropriate steps to safeguard Evidence and protect the rights of those involved; or
 7. The research community or the public should be informed.
- K. Interim Administrative Actions. In the event that (a) any condition described in Section III.J exists or (b) such actions are necessary to prevent the loss, alteration or fraudulent creation of relevant Evidence, the Research Integrity Officer, in consultation with other institutional officials and ORI, may also take the following interim administrative actions:
1. Additional monitoring of the research process and the handling of federal funds and equipment;
 2. Reassignment of personnel or of the responsibility for the handling of federal funds and equipment;
 3. Additional review of research data and results;

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4. Delaying publication; or
 5. Taking necessary human resources-related actions, including placing personnel on administrative leave.
- L. Statute of Limitations.
1. This Policy only applies to Research Misconduct occurring within six (6) years of the date on which HHS or CSMC receives an Allegation.
 2. The statute of limitations set forth in Section III.L.1 shall not apply in the following instances:
 - a. The Respondent continues or renews any incident of alleged Research Misconduct that first occurred more than six (6) years prior to the applicable Allegation through the citation, republication or other use for the potential benefit of the Respondent of the Research Record that is alleged to have been fabricated, falsified, or plagiarized.
 - b. If ORI or CSMC, following consultation with ORI, determines that the alleged Research Misconduct, if it occurred, would possibly have a substantial adverse effect on the health or safety of the public.
 - c. If HHS or CSMC received the Allegation of Research Misconduct before June 16, 2005.

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IV. ASSESSMENT

A. Filing an Allegation.

1. Any individual or entity (whether or not affiliated with CSMC) may file an Allegation. To file an Allegation, the Complainant should submit the Allegation in writing or orally to his or her supervisor, who shall then promptly and confidentially notify the applicable Department Chair. The Complainant may also submit the Allegation directly to the applicable Department Chair, the Research Integrity Officer, the SIC Chair, the Senior Vice President for Academic Affairs and Dean of the Medical Faculty, or other CSMC institutional official, who shall immediately forward the Allegation to the Research Integrity Officer, who will direct the Allegation to the appropriate Department Chair. The Department Chair shall be responsible for maintaining the confidentiality of the Allegation and conducting the initial Assessment in consultation with the Research Integrity Officer.
2. If submitted in writing, the Allegation may be submitted by email or letter. Alternatively, if the Complainant prefers, he or she can complete an *Allegation Intake and Assessment Form*, which can be obtained in the Corporate Compliance Department office, located at 6500 Wilshire Blvd., Suite 760, Los Angeles, CA 90048, during normal business hours, or on the Corporate Compliance Department's internal CSMC intranet site. If submitted verbally, the Complainant may report the Allegation using the CSMC Corporate Compliance Hotline number, 1-800-CEDARS5 or 1-800-233-2775. The compliance officer monitoring information left on the hotline will promptly refer the Allegation to the Research Integrity Officer.
3. Although an Allegation may be submitted anonymously, anonymous Allegations may be more difficult to assess. Anonymous Allegations will be discouraged in order to increase the likelihood that an Allegation contains sufficient credible, specific and verifiable information to proceed with an Inquiry.
4. Any CSMC Member who receives an Allegation will immediately forward the Allegation to the Research Integrity Officer, who will direct the Allegation to the appropriate Department Chair. The Research Integrity Officer will be present or available throughout the Assessment to advise and provide administrative and logistical support to the Department Chair as needed.

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5. Within five (5) days of receiving the Allegation, the Research Integrity Officer shall send written acknowledgement of the Allegation to the Complainant.
- B. Assessing an Allegation. Within five (5) days of receiving the Allegation, the Department Chair will undertake an Assessment in consultation with the Research Integrity Officer. The purpose of the Assessment is to determine whether (a) the Allegation is sufficiently credible and specific so that potential Evidence of Research Misconduct can be identified; (b) the Allegation relates to Research Misconduct as opposed to other forms of non-compliance; (c) the Research Misconduct concerns a research activity governed by Section 93.102 of Applicable Law; and (d) based on these conclusions, an Inquiry is warranted. The purpose of the Assessment is *not* to conduct a review of the Evidence. Within ten (10) days of receiving the Allegation, the Department Chair will complete the *Allegation Intake and Assessment Form* documenting his or her conclusions with respect to the Allegation and shall transmit the completed *Allegation Intake and Assessment Form* to the Research Integrity Officer and the Deciding Official. If the Allegation contains sufficient Evidence of Research Misconduct, the Department Chair will also document whether potential ORI reporting obligations attach pursuant to Sections III.B and III.J.
- C. Deciding Official's Review of the Allegation Intake and Assessment Form. After consulting with the Department Chair, the Research Integrity Officer and/or other CSMC officials, the Deciding Official makes the determination, based on the completed *Allegation Intake and Assessment Form*, as to whether an Inquiry is warranted. The Deciding Official shall announce his or her determination in writing.

V. INQUIRY

- A. Purpose. The purpose of the Inquiry is to conduct an initial and preliminary review of the Evidence to determine whether an Investigation is warranted.
- B. Timing. The Inquiry must be completed within sixty (60) calendar days of its initiation unless circumstances clearly warrant a longer period. Any extension by the SIC Chair of this 60-day period must be for good cause and must be recorded in the Inquiry file. The Inquiry is completed by CSMC when the Deciding Official has decided whether an Investigation is warranted.
- C. Initiation. To initiate the Inquiry, the Research Integrity Officer informs the SIC Chair that an Allegation has been reported and has met the Assessment standard. The Research

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Integrity Officer will notify any other appropriate CSMC officials by providing them with copies of the *Allegation Intake and Assessment Form* and the Deciding Official's written determination with respect to the Allegation. The Research Integrity Officer will coordinate any other compliance efforts required by CSMC's general compliance policy.

- D. Notification to the Respondent. The Research Integrity Officer shall advise the relevant Department Chair to notify the Respondent of the Allegation and the decision to move to the Inquiry stage in writing on or before the initiation of the Inquiry. The notice of Inquiry to the Respondent must include sufficient information to reasonably inform the Respondent of the nature of the Allegation, the Inquiry process and the members of the Inquiry Committee. If the Inquiry subsequently identifies additional Respondents, the Research Integrity Officer shall advise the relevant Department Chair(s) to notify such additional Respondents of the Inquiry in accordance with this Section V.D.
- E. Inquiry Committee Composition.
1. The SIC Chair selects members for the Inquiry Committee by screening the standing members of the SIC, including faculty with the appropriate academic expertise but without bias or unresolved personal, professional or financial conflicts of interest or the appearance thereof. The Research Integrity Officer will be available to assist the SIC Chair with conflict of interest determinations. As part of the selection process, the SIC Chair shall ask potential Inquiry Committee members to self-disclose any bias or conflicts of interest. If necessary to ensure that the Inquiry Committee is comprised of a sufficient number of unbiased members with the necessary expertise, the SIC Chair may appoint Inquiry Committee members other than the standing members of the SIC. The SIC Chair will notify the Research Integrity Officer of his or her selection of Inquiry Committee members.
 2. The Research Integrity Officer shall promptly inform the Respondent of the composition of the Inquiry Committee. The Research Integrity Officer shall also notify the Respondent that (a) he or she has the right to submit a written objection to any appointed member of the Inquiry Committee based on bias or conflict of interest within five (5) days, for consideration by the SIC Chair, and (b) if the Respondent does not submit an objection within such 5-day period, the Inquiry Committee shall proceed as selected by the SIC Chair. If the Respondent submits such an objection, the SIC Chair, in consultation with the Research

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Integrity Officer, shall (i) review the relevant facts, (ii) if any bias or conflict of interest exists, promptly appoint an appropriate substitute member, and (iii) notify the Respondent of his or her decision.

F. Record Sequestration.

1. Either before or when the applicable Department Chair notifies the Respondent of the Inquiry, the Research Integrity Officer will promptly locate, collect and sequester any Research Records or other documents predicted to be relevant to the Inquiry, in order to prevent the loss, alteration or fraudulent creation of relevant documents.
2. The Research Integrity Officer will sequester all original records, and will only sequester a copy when the original cannot be located or where the Research Records or Evidence encompass scientific instruments shared by a number of users. Where the Research Records or Evidence encompass scientific instruments shared by a number of users, custody may be limited to copies of the data or Evidence on such instruments, so long as those copies are substantially equivalent to the evidentiary value of the instruments.
3. Upon sequestration, the Research Integrity Officer will inventory the documents and will update the inventory as needed.
4. Where appropriate, the Research Integrity Officer shall direct the applicable Department Chair to give the Respondent copies of, or reasonable supervised access to, the sequestered records.
5. The Research Integrity Officer will undertake all reasonable and practical efforts to take custody of additional Research Records or Evidence discovered during the course of the Research Misconduct Proceeding.

- G. Conducting the Inquiry. The SIC Chair will direct the Inquiry. The Research Integrity Officer will be available throughout the Inquiry to advise and provide administrative and logistical support to the SIC Chair and the Inquiry Committee as needed, and will manage communications with ORI and the Respondent prior to the commencement of, and following the completion of, the Inquiry.

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- H. Fact Finding. Fact finding and interviews will be kept to the minimum required to determine whether to conduct an Investigation. The SIC Chair may conduct preliminary interviews and speak with the Complainant, the Respondent and other key witnesses who know or may know relevant information at the commencement of the Inquiry process (including prior to the Inquiry Committee's first meeting). If the Committee determines that additional clarification or follow-up is needed at any time during the Inquiry process, the Inquiry Committee shall have the right to conduct formal interviews with key witnesses. The Research Integrity Officer shall notify any such witnesses by e-mail in advance of the interview date.
- I. Charge to the Inquiry Committee; First Meeting.

The SIC Chair will prepare a charge for the Inquiry Committee that:

1. Sets forth the time for completion of the Inquiry;
2. Describes the Allegation and any related issues identified during the Assessment;
3. States that the purpose of the Inquiry is to conduct an initial and preliminary review of the Evidence, including the testimony of the Respondent, Complainant and key witnesses, in order to determine whether an Investigation is warranted and not to determine whether Research Misconduct definitely occurred or who was responsible;
4. States that an Investigation is warranted if the Inquiry Committee determines that: (a) there is a reasonable basis for concluding that the Allegation falls within the definition of Research Misconduct and is within the jurisdictional criteria of Section 93.102(b) of Applicable Law; and (b) the Allegation may have substance, based on the Inquiry Committee's review during the Inquiry; and
5. Informs the Inquiry Committee that they are responsible for preparing or directing the preparation of a written Inquiry Report that meets the requirements of this Policy and Section 93.309(a) of Applicable Law.

At the Inquiry Committee's first meeting, the SIC Chair will review the charge with the Inquiry Committee, discuss the Allegations, any related issues, and the appropriate procedures for conducting the Inquiry, summarize any of his or her initial findings discovered during preliminary interviews with key witnesses in accordance with Section

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V.H., assist the Inquiry Committee with organizing plans for the Inquiry, and answer any questions raised by the Inquiry Committee.

J. Inquiry Report.

1. The SIC Chair shall deliver the final Inquiry Report to the Deciding Official, with a copy to the Research Integrity Officer. The Inquiry Report will include: (a) the name and position of the Respondent; (b) details of the Allegation of Research Misconduct; (c) the PHS Support, including grant numbers, grant applications, contracts, and publications listing PHS Support, if any; (d) a detailed description of what Evidence was reviewed; (e) a summary of relevant interviews; (f) the conclusions of the Inquiry; (g) a recommendation for the Deciding Official and the basis for the recommendation; and (h) an explanation of whether the Inquiry Committee has found possible Evidence of honest error or difference of opinion for consideration at the Investigation Stage. However, the Inquiry Committee shall not recommend that an Allegation be dismissed on the grounds of such possible Evidence. CSMC legal counsel shall review the Inquiry Report for legal sufficiency and make modifications as appropriate in consultation with the Inquiry Committee.
2. The Inquiry Report may recommend that:
 - a. An Investigation is not warranted because a preliminary review of the Evidence suggests that the Allegation does not have substance. In this case, the report will contain sufficiently detailed documentation of the Inquiry to permit a later assessment by ORI of the reasons CSMC decided not to conduct an Investigation.
 - b. An Investigation is not warranted because the alleged misconduct does not constitute Research Misconduct and therefore is outside the scope of this Policy. In this case, the Research Integrity Officer will refer the matter to the proper CSMC committee, CSMC Member, CSMC Institutional Review Board or the appropriate government office. In this case, the report will contain sufficiently detailed documentation of the Inquiry to permit a later Assessment by ORI of the reasons CSMC decided not to conduct an Investigation.
 - c. An Investigation is warranted.

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- K. Deciding Official's Review of the Inquiry Report.
1. After consulting with the SIC Chair, the Research Integrity Officer and/or other CSMC officials, the Deciding Official makes the determination, based on the final Inquiry Report and the Evidence collected during the Inquiry, as to whether sufficient evidence of possible Research Misconduct exists to warrant an Investigation.
 - a. In the event that the Inquiry Committee recommends that the Inquiry proceed to the Investigation stage, the Deciding Official may not override that decision and must proceed to initiate the Investigation.
 - b. In the event that the Inquiry Committee recommends that the Inquiry not proceed to the Investigation stage, the Deciding Official may accept this recommendation or may independently decide, based on the Inquiry Report, that an Investigation is warranted, and in such case must proceed to initiate the Investigation.
 2. The Inquiry is completed upon the Deciding Official announcing his or her decision in writing. In the event that the Deciding Official determines to override the Inquiry Committee's recommendations in accordance with Section V.K.1.b, his or her written decision must explain the grounds for such override determination.
 3. The Research Integrity Officer and the Department Chair must provide the Respondent with written notice of whether the Deciding Official has found that an Investigation is warranted, and if so, of the intention to proceed with an Investigation on or before initiating the Investigation. The notice shall inform the Respondent that (a) his or her comments in response to the Inquiry Report, if any, are due back to the Research Integrity Officer within five (5) working days; and (b) he or she may obtain the assistance of legal counsel, at his or her own expense, in order to assist the Respondent in preparation for the Investigation. In all cases, the notice should include a copy of the final Inquiry Report, a reference to or copy of Applicable Law, and a copy of this Policy. The Respondent's comments shall be attached to the final Inquiry Report.
 4. If ORI initiated the Inquiry, the Research Integrity Officer must provide ORI with copies of the Deciding Official's written decision and the Inquiry Report within

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thirty (30) days of the Deciding Official's announcement of his or her decision. If ORI did not initiate the Inquiry, the Research Integrity Officer does not need to notify ORI of a decision not to proceed with an Investigation. The Research Integrity Officer must provide the following information to ORI upon request: (a) copies of the CSMC policies and procedures under which the Inquiry was conducted; (b) copies of the research records and Evidence reviewed, transcripts or recordings of any interviews, and all other relevant documents; and (c) the charges to be considered in the Investigation. The Research Integrity Officer will also notify those institutional officials who need to know of the Deciding Official's decision.

VI. INVESTIGATION

- A. Purpose. The purpose of the Investigation is to explore in detail the Allegation(s), to examine the Evidence in depth, to determine if further Evidence needs to be collected, and to make a formal finding of whether Research Misconduct has been committed and, if so, by whom. The Investigation will also identify any additional instances of Research Misconduct that would justify extending the scope of the Investigation beyond the original Allegation(s). The Investigation Committee will diligently pursue all significant issues and leads discovered which are determined by the Investigation Committee to be relevant to the Investigation, including any Evidence of additional instances of possible Research Misconduct.
- B. Timing.
1. CSMC must initiate an Investigation within thirty (30) calendar days after the Deciding Official determines that an Investigation is warranted. The Research Integrity Officer initiates the Investigation by providing a directive to the Investigation Committee Chair to form an Investigation Committee.
 2. An Investigation must be completed within one-hundred and twenty (120) days after the Investigation is initiated. An Investigation is complete upon filing the final Investigation Report with ORI, if ORI reporting obligations attach pursuant to Section III.B, and upon filing the final Investigation Report with the Deciding Official, if ORI reporting obligations do not attach pursuant to Section III.B. If ORI reporting obligations attach, and the Investigation Committee determines at any time that it cannot complete the Investigation within the 120-day timeframe, the Research Integrity Officer must submit a written request for an extension to ORI,

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and during the extension period the Research Integrity Officer will file periodic progress reports as may be requested from time to time by ORI.

C. Notices. The Research Integrity Officer must notify:

1. The Respondent, if new Allegations are alleged against the Respondent during the course of the Investigation. CSMC must give written notice of such new Allegations within a reasonable amount of time. The requirements for the initial notice of the Investigation to the Respondent are set forth in Section V.K.3;
2. ORI of the decision to proceed with an Investigation, if ORI reporting obligations attach pursuant to Section III.B. The Research Integrity Officer shall notify ORI on or before the date on which the Investigation begins, shall provide the final Inquiry Report to ORI and shall describe any interim institutional action required and its effect on the progress of the research;
3. The granting agency, if any;
4. If the research in question triggers such reporting pursuant to the terms of the applicable Academic Affiliation Agreement, the relevant institutional officials of any institutions where the Respondent holds a faculty appointment (if the Respondent holds a faculty appointment with UCLA, then pursuant to Section 2.7(a) of the Medical Center's Academic Affiliation Agreement with UCLA, UCLA and the director of UCLA graduate medical education programs shall be notified); and
5. Any other individuals on a need-to-know basis as determined by the Investigation Committee Chair, including but not limited to the principal investigator of the research in question (if such principal investigator is not the Respondent), the applicable Department Chair, and collaborators or supervisors of the Respondent.

D. Investigation Committee.

1. The Investigation Committee will include the Investigation Committee Chair and other CSMC Members selected by the Investigation Committee Chair who have expertise in the specific scientific discipline(s) involved to review research and publications. The members of the Investigation Committee shall be impartial

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and shall not have participated actively in the Assessment or Inquiry as a Complainant, witness, Department Chair undertaking the Assessment, or Inquiry Committee member, and shall not have bias, a conflict of interest or the appearance thereof. As part of the selection process, the Investigation Committee Chair shall ask potential Investigation Committee members to self-disclose any bias or conflicts of interest. The Investigation Committee Chair, in consultation with the Research Integrity Officer and other institutional officials, will review the committee membership qualifications to select an appropriate group to perform the Investigation. The Research Integrity Officer will be available to assist the Investigation Committee Chair with conflict of interest determinations.

2. The Research Integrity Officer shall promptly inform the Respondent of the composition of the Investigation Committee. The Research Integrity Officer shall also notify the Respondent that (a) he or she has the right to submit a written objection to any appointed member of the Investigation Committee based on bias or conflict of interest within five (5) days, for consideration by the Investigation Committee Chair, and (b) if the Respondent does not submit an objection within such 5-day period, the Investigation Committee shall proceed as selected by the Investigation Committee Chair. If the Respondent submits such an objection, the Investigation Committee Chair, in consultation with the Research Integrity Officer, shall (i) review the relevant facts, (ii) if any bias or conflict of interest exists, shall promptly appoint an appropriate substitute member, and (iii) notify the Respondent of his or her decision.
3. The Research Integrity Officer will define the subject matter of the Investigation in a written charge to the Investigation Committee that: (a) describes the Allegations and related issues identified during the Inquiry; (b) identifies the Respondent; (c) informs the Investigation Committee that it must conduct the Investigation as prescribed in this Policy and Applicable Law; (d) defines Research Misconduct; (e) informs the Investigation Committee that it must evaluate the Evidence and testimony to determine whether, based on a preponderance of the Evidence, Research Misconduct occurred and, if so, the type and extent of it and who was responsible; (f) informs the Investigation Committee that, in order to determine that the Respondent committed Research Misconduct, it must find that a preponderance of the Evidence establishes that: (i) Research Misconduct, as defined in this Policy, occurred (the Respondent has the burden of proving by a preponderance of the Evidence any affirmative defenses raised, including honest error or a difference of

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opinion); (ii) the Research Misconduct is a significant departure from accepted practices of the relevant research community; and (iii) the Respondent committed the Research Misconduct intentionally, knowingly, or recklessly; and (g) informs the Investigation Committee that it must prepare or direct the preparation of a written Investigation Report that meets the requirements of this Policy and Section 93.313 of Applicable Law.

4. The Investigation Committee will promptly convene the first meeting as soon as its membership is finalized. At this initial meeting, the Investigation Committee should: (a) review the charge prepared by the Research Integrity Officer in accordance with Section VI.D.3; (b) prepare an Investigation plan which documents an inventory of all previously secured Evidence and testimony; (c) make determinations regarding necessary witnesses, proposed schedule of meetings, briefing of experts, interviews and whether additional Evidence needs to be secured; (d) determine how Evidence (*i.e.*, scientific, statistical, forensic, etc.) will be analyzed; and (e) create a plan to draft and circulate the Investigation Report.
 5. If the members of the Investigation Committee do not have sufficient expertise in the area of research under review to carry out a thorough and authoritative evaluation of the relevant evidence or otherwise believe that the review and advice of outside expert(s) is warranted, the Investigation Committee, in consultation with the Research Integrity Officer, shall arrange for expert(s) in the relevant field of research from outside CSMC to review the relevant evidence and provide input to the Investigation Committee regarding the validity of the allegations of Research Misconduct.
 6. The Research Integrity Officer will be present or available throughout the Investigation to advise the Investigation Committee Chair as needed.
- E. Record Sequestration. To the extent that such steps were not already taken at the Assessment or Inquiry stages, the Research Integrity Officer will take all reasonable and practical steps to obtain custody of all of the Research Records and Evidence needed to conduct the Research Misconduct Proceeding, inventory the records and Evidence, and sequester them in a secure manner. The Research Integrity Officer will take custody of the records: (a) before or at the time the Research Integrity Officer notifies the Respondent; and (b) whenever additional items become known or relevant to the Investigation. During the Investigation, the Investigation Committee files are maintained

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- by the Research Integrity Officer. The Deciding Official may grant permission to the Research Integrity Officer for the release of files as permitted by law or regulation. In general, access to the files during the Investigation is allowed only to the Deciding Official, the Research Integrity Officer, the Investigation Committee Chair, CSMC legal counsel or Investigation Committee members for the purposes of the Investigation.
- F. Witness Interviews. The Investigation Committee should interview the Respondent, the Complainant and any other available person who has been reasonably identified as having information regarding any relevant aspects of the Investigation, including witnesses identified by the Respondent. The Research Integrity Officer shall provide witnesses with prior written notice of scheduled interviews; such written notice shall include information regarding the date, time and place of the interview as well as relevant background information regarding the Investigation. Each interview shall be recorded or transcribed. The recording or transcript shall be provided to the interviewee for correction and the recording or transcription is included in the record of the Investigation. Changes to the transcript will only be made to correct factual errors, although a witness may supplement his or her answers in writing for clarification.
- G. Investigation Decision. Upon completion of its fact-finding, the Investigation Committee, in consultation with the Research Integrity Officer, shall prepare a draft Investigation Report pursuant to Section VI.I.4.
- H. Comment by Respondent. The Research Integrity Officer must forward a copy of the draft Investigation Report to the Respondent within ninety (90) calendar days of initiating the Investigation. The Research Integrity Officer shall concurrently provide to the Respondent a copy of, or supervised access to, the Evidence on which the Investigation Report is based, as well as copies of this Policy and the Applicable Law. The Research Integrity Officer shall inform the Respondent that his or her comments in response to the Investigation Report, if any, are due back to the Research Integrity Officer as soon as possible in order to avoid further delays to the research in question, but no later than thirty (30) calendar days from the date on which the Respondent receives the Investigation Report. The Respondent's comments shall be made a part of the Investigation record.
- I. Findings of the Investigation. After reviewing the Respondent's comments, the Investigation Committee, in consultation with the Research Integrity Officer, must reach a final decision as to whether it believes the Respondent committed Research Misconduct. The Research Integrity Officer will assist the Investigation Committee in

Title: Research Misconduct Policy: Academic Affairs - Administration

Home Department: Academic Affairs / Administration

Document Owner: Nicole Leonard (Vice President)

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finalizing the Investigation Report, including ensuring that the Respondent's comments are included and considered. The Research Integrity Officer will submit the completed Investigation Report, with each page marked "Confidential", to the Deciding Official.

1. If the Investigation Committee concludes that the Respondent has not engaged in Research Misconduct, the Investigation shall be deemed closed. CSMC must keep sufficiently detailed documentation of any Investigation in which there is not a finding of Research Misconduct to permit a later assessment by ORI of the reasons for this determination.
2. If the Investigation Committee concludes that the Respondent has engaged in misconduct but the misconduct is not Research Misconduct, the Investigation shall be deemed closed and the Deciding Official will refer the matter to the appropriate department, person or committee within CSMC for further action. CSMC must keep sufficiently detailed documentation of any Investigation in which there is not a finding of Research Misconduct to permit a later assessment by ORI of the reasons for this determination.
3. If the Investigation Committee concludes that the Respondent has engaged in Research Misconduct, the Deciding Official shall make the final decision regarding the sanctions to be imposed on the Respondent within fifteen (15) calendar days after receipt of the final Investigation Report, in accordance with Section VI.J.
4. The Investigation Report must contain the following elements:
 - a. Describe the policies and procedures followed to conduct the Investigation authoritatively, diligently, thoroughly and within the bounds of reasonable confidentiality.
 - b. Describe how, and from whom, information relevant to the Investigation was obtained. All facts of the case will be clearly and fully detailed to provide sufficient documentation for any required future review.
 - c. Describe the nature of the Allegations.
 - d. Describe any PHS Support, including any grant numbers, grant applications, contracts, and publications listing PHS Support.

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- e. Identify and summarize the Research Records, Evidence reviewed, and any Evidence taken into custody but not reviewed.
- f. For each separate Allegation of Research Misconduct identified during the Investigation, provide a finding as to whether Research Misconduct did or did not occur and if so:
 - (i) identify whether the Research Misconduct consisted of Falsifications, Fabrication or Plagiarism, and if the Research Misconduct was intentional, knowing or in reckless disregard;
 - (ii) summarize the facts and the analysis which support the conclusion and consider the merits of any reasonable explanation by the Respondent(s);
 - (iii) identify the specific PHS support;
 - (iv) identify whether any publications need correction or retraction;
 - (v) identify the person(s) responsible for the misconduct;
 - (vi) list any current support or known applications or proposals for support that the Respondent has pending with non-PHS federal agencies; and
 - (vii) list the sanctions recommended by the Investigation Committee, if any.
- g. Describe a plan for proactive protection of reputations and positions of those involved.
- h. Include and consider any comments made by the Respondent on the draft Investigation Report.

J. Sanctions.

- 1. As part of the final Investigation Report, the Investigation Committee, in

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consultation with the Research Integrity Officer, shall recommend sanctions if there is a finding of Research Misconduct. The Deciding Official will review this recommendation and impose such institutional actions and sanctions as he or she deems appropriate, including sanctions that may be different from or in addition to those recommended by the Investigation Committee. These actions will be evaluated with the Research Integrity Officer, the applicable Department Chair and CSMC legal counsel before they are finalized and will be subject to any relevant CSMC disciplinary or medical staff privileging policies.

2. The Deciding Official's determination regarding sanctions shall be documented in writing and made part of the Investigation file. In the event that the Deciding Official determines to override the Investigation Committee's recommendations in accordance with Section VI.J.1, his or her written decision must explain the grounds for such override determination.
3. Sanctions may include, but are not limited to the following:
 - a. Notification of editors of journals to retract abstracts and papers emanating from the research;
 - b. Notification of institutions and granting agencies with whom the Respondent previously had been affiliated, if there is reason to believe that the validity of previous research might be questionable;
 - c. Suspension or termination of the Respondent's CSMC contracts, privileges, employment or severance of other forms of CSMC association in compliance with CSMC;
 - d. Determination that the Respondent cannot participate in research and/or associate with CSMC for a specified period of time, including indefinitely;
 - e. Repossession of any and all CSMC space, equipment, supplies, software, lab notebooks, data cell lines, samples, research animals, patent rights or royalties, or any other CSMC resources previously accessible to the Respondent;
 - f. Where appropriate under the applicable Academic Affiliation Agreement, filing a complaint with the relevant institutional officials of any

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institutions where the Respondent holds a faculty appointment, in accordance with such institutions' relevant policies and procedures; and/or

- g. Recommendation that appropriate legal action on behalf of CSMC be commenced against the Respondent.
 4. Consideration will be given, in consultation with legal counsel, to whether CSMC should release information about the incident to the public press, particularly when public funds were used to support the research in question.
- K. The Research Integrity Officer shall notify:
1. ORI in writing, if ORI reporting obligations attach pursuant to Section III.B, of the final outcome of the Investigation and must provide ORI with a copy of the final Investigation Report and CSMC's decision with respect to sanctions. Such written notice shall describe any pending or completed administrative actions against the Respondent, and shall state whether CSMC has accepted the Investigation Committee's findings. If not previously provided, the ORI notice should also include a copy of this Policy;
 2. The Respondent of the final outcome of the Investigation, in accordance with Section VI.M;
 3. If there was a finding of Research Misconduct, law enforcement agencies, professional societies, professional licensing boards, editors of journals, collaborators of the Respondent in the Research or other relevant parties, when appropriate; and
 4. Where appropriate under the applicable Academic Affiliation Agreement, the relevant institutional officials of any institutions where the Respondent holds a faculty appointment.
- L. Compliance with Notification Requirements. The Research Integrity Officer is responsible for ensuring CSMC's compliance with all notification requirements of funding or sponsoring agencies.
- M. Notifying the Respondent. The final Investigation Report shall be presented to the Respondent in a prearranged private meeting with relevant CSMC institutional officials,

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including but not limited to the Deciding Official, the Research Integrity Officer, the applicable Department Chair, the Respondent's immediate supervisor, CSMC legal counsel, and the Respondent's legal counsel.

- N. Restoration of Respondent's Reputation. If CSMC finds no evidence of Research Misconduct, and, where ORI reporting obligations attach pursuant to Section III.B, ORI concurs, the Deciding Official and/or the Research Integrity Officer will consult with the Respondent to determine reasonable efforts to restore the Respondent's reputation. Any CSMC actions to restore the Respondent's reputation must be approved by the Deciding Official.
- O. Cooperation with ORI.
1. In those cases where CSMC has submitted the final Investigation Report to ORI, ORI will review the document and decide whether it agrees or disagrees with CSMC's determination, or whether it requires additional information. CSMC Members will cooperate with ORI during its review of the final Investigation Report, and should consult with the Research Integrity Officer if they are unsure how to handle a request for information from ORI.
 2. If the Respondent appeals to the Departmental Appeals Board a finding of Research Misconduct, ORI may request the cooperation of CSMC Members. CSMC Members will cooperate with ORI during its review of the final Investigation Report, and should consult with the Research Integrity Officer if they are unsure how to handle an inquiry or request from ORI.
 3. In general, CSMC and all CSMC Members will cooperate with and assist ORI and HHS, as needed and in accordance with Applicable Law, to carry out any administrative actions HHS may impose as a result of a final finding of research misconduct by HHS.
- P. Assurance. The Research Integrity Officer must file an assurance with ORI on behalf of CSMC that CSMC: (1) has written policies and procedures in compliance with the Applicable Law for inquiring into and investigating Allegations of Research Misconduct; and (2) complies with its own policies and procedures and the requirements of the Applicable Law.

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VIII. AUTHOR AND APPROVING AUTHORITY

- A. Author:
James D. Laur, Esq.
Vice President for Legal Affairs

- B. Approving Authority:
Shlomo Melmed, M.D.
Senior Vice President for Academic Affairs and Dean of the Medical Faculty

Verification of approval on file with Corporate Compliance Department

Original Effective Date: 11/1/09

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IX. APPENDIX

CONFIDENTIALITY ACKNOWLEDGEMENT: *Research Misconduct Policy*

I, _____, acknowledge that as a result of my involvement in a Research Misconduct Proceeding at Cedars-Sinai Medical Center, I may see, become aware of or possess information of a confidential nature. I recognize that I may have a legitimate need to know and make use of confidential information in the course of the Research Misconduct Proceeding. I also understand that I have an obligation to protect against the inappropriate or unauthorized use or release of this information.

I have read Cedars-Sinai Medical Center's *Research Misconduct Policy* (Policy No. RA-200.3) and shall comply with the confidentiality requirements set forth in the Policy. I shall hold all confidential information that I receive in connection with the Research Misconduct Proceeding, including the content of any information or documents, in the strictest confidence. Should I be asked by a CSMC institutional official to return or destroy all copies of confidential information I possess or have access to, I shall do so promptly.

I have received and read this Confidentiality Acknowledgement and understand the requirements set forth herein.

By: _____
Name: _____
Title: _____
Date: _____

Title: Patent & Invention Policy: Technology Transfer**Home Department: Technology Transfer****IMPORTANT NOTICE:****The official version of this document is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.****I. POLICY**

Cedars-Sinai Medical Center ("Cedars-Sinai" herein) seeks to establish and confirm its proprietary interest in all Inventions (as defined below) and any related intellectual property rights created under circumstances where such Inventions are "conceived" (as defined below) by a Cedars-Sinai employee, independent contractor, Medical Staff member (of any staff category), principal investigator, physician-in-training, professional-in-training (with or without stipend), or by others engaged in medical education or research at Cedars-Sinai (collectively "Inventor" herein) regardless of the Inventor's employment, contractual status or funding source. Cedars-Sinai also seeks to define an Inventor's interest in and rights to Inventions conceived by him or her and the duty of such Inventors to promptly disclose such Inventions to Cedars-Sinai.

For the purpose of this Policy, "Invention" shall mean every invention, system, design, report, document, manual, program code, listing, software, firmware, hardware, database, product, specification, application, routine, sub-routine, technique, know-how, formula, device, process, idea, improvement, discovery, information, work of authorship and work fixed in a tangible medium, whether or not protected or protectable by applicable patent, copyright, trademark, trade secret or other laws. For the purpose of this Policy, "conceive" shall mean developed, prepared, created, reduced to practice or made in whole or in part within the scope of the Inventor's employment or activity at Cedars-Sinai, through use of Cedars-Sinai's facilities, equipment, supplies, information, personnel, independent contractors or trade secrets, or as specifically ordered, commissioned or acquired by Cedars-Sinai.

It is the policy of Cedars-Sinai that, subject to the determination of Cedars-Sinai's Technology Transfer Office (as defined below), all interests in and rights to all such Inventions and any related intellectual property rights shall be owned, held and exercised exclusively by Cedars-Sinai.

However, it is recognized that such Inventions and any related intellectual property rights may, and frequently do, involve equities beyond those of the Inventor himself or herself. The particular assignment of duties, or conditions of employment, the possible claims of a cooperating agency (as in research supported from extramural funds) and other situations may give rise to a complex of interrelated equities or rights involving Cedars-Sinai and a cooperating agency or others. This Policy is therefore adopted for the purpose of providing the means by which such rights and equities shall be appraised and agreements respecting the proper disposition thereof shall be reached, to comply with all federal and state legal requirements, to assure that all actions regarding title to Inventions are properly taken, to determine the relative rights and equities of all parties concerned, to facilitate applications, filings, and registration on Inventions and any related intellectual property rights, to facilitate negotiations and agreements with third parties concerning Inventions, to assure equitable distributions of royalties, fees and other payments, if any, to obtain

Title: Patent & Invention Policy: Technology Transfer**Home Department: Technology Transfer****IMPORTANT NOTICE:****The official version of this document is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.**

funds for research and to provide a uniform procedure in matters involving intellectual property rights where such matters originate within Cedars-Sinai or are related to employment at Cedars-Sinai or arise from the utilization of Cedars-Sinai research facilities, equipment, supplies, information, personnel, independent contractors or trade secrets.

1. Technology Transfer Office

All matters relating to Inventions and related intellectual property rights in which Cedars-Sinai is in any way concerned shall be administered by Cedars-Sinai's Technology Transfer Office (the "Technology Transfer Office" or "TTO" herein).

- a. The TTO shall consist of staff appointed by the President of Cedars-Sinai or his designee.
- b. The TTO shall consist of the number of persons deemed appropriate by the President or his designee, and shall report to the President or his designee.
- c. The TTO shall provide the administrative support for all matters associated with the implementation of this Policy, subject to reimbursement of costs and other expenses as provided by Section 3(d) hereof.

2. Powers and Duties of the Technology Transfer Office with Respect to Inventions

Subject at all times to the sole and exclusive judgment, authority and approval of the President of Cedars-Sinai, including, without limitation, Cedars-Sinai's rights to execute any and all documents concerning Inventions and any related intellectual property rights, the following powers and duties shall be exercised by the TTO:

- a. To appoint or engage the services of one or more experts, or to appoint or engage a committee of experts to examine the merits of each Invention when deemed appropriate by the TTO and to cause such experts or committee to report its findings to the TTO. Without limiting the generality of the foregoing, the TTO may engage the services of consultants to evaluate, review or assist the TTO in any way concerning the merits, characteristics or any other matter concerning any Invention.
- b. To determine the relative equities claimed by the Inventor or by a cooperating agency, if any, or any other persons (including, without limitation, individuals who meaningfully participated in the generation, development or commercialization of an Invention, but who are not recognized as "inventors" under U.S. Patent Law), and to establish an agreement among all parties concerned with respect to such equities, if necessary.

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- c. To authorize the making and processing of applications, filings and registrations for the intellectual property protection of Inventions and any related intellectual property rights, to take any such other actions to perfect, maintain and protect such rights as the TTO deems appropriate and to engage the services of counsel and consultants for matters pertaining thereto, the prosecution thereof, and any litigation that may arise therefrom.
- d. To assign or release Cedars-Sinai's rights to an Invention and any related intellectual property rights to the Inventor(s) in unusual circumstances where the equities so indicate, as shall be determined by the TTO, subject to the Inventor's execution of an equitable license, royalty or other agreement with Cedars-Sinai in consideration of Cedars-Sinai's proprietary interest in the rights to such Invention and provision for the reimbursement of any costs and expenses Cedars-Sinai may have incurred in protecting or enforcing the attendant intellectual property rights.
- e. To negotiate any and all agreements or documents related to Inventions and any related intellectual property rights including, without limitation, the sale, lease, pledge, encumbrance, hypothecation, license, sublicense, assignment, reassignment, manufacturing, processing, marketing, advertising and other use or exploitation thereof.
- f. To arrange for and direct the collection of all royalties, fees and other payments, and the distribution thereof to those entitled thereto, as determined by the TTO.
- g. To assist Cedars-Sinai in negotiating with funding agencies and in filing appropriate elections to retain title to Inventions made as a result of research carried on under grants, contracts or cooperative agreements.
- h. In its consideration of all matters relating to each particular Invention or situation, the TTO shall consider applicable laws, rules, regulations, ordinances, court decisions and treaties.
- i. To make such reports and recommendations as required.
- j. To ensure compliance by Cedars-Sinai with applicable laws, rules and regulations pertaining to Inventions that result from federally funded research and Cedars-Sinai's role in the commercialization thereof. When an Inventor discloses an Invention in writing to the TTO, which is the result of research which is partially or fully-funded by a federal or state agency, the TTO shall disclose in writing to the relevant agency the identity of the Inventors and the contract under which the Invention was made. The TTO shall also disclose and provide to the relevant agency such additional information and documentation as and when required under applicable laws, rules, regulations and the terms of the underlying funding agreement, including, without limitation, notice regarding the TTO's decision whether or not to retain title to any such Invention, notices pertaining to prosecution or abandonment of any related

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patent rights, and periodic reports pertaining to utilization or efforts to obtain utilization of such Inventions.

3. General Policies Applicable to Inventions

- a. Inventors shall make appropriate reports to the TTO of any Inventions they have conceived using the invention disclosure form currently in use by the TTO, as may be updated from time to time.
- b. An agreement to promptly disclose Inventions to Cedars-Sinai shall be mandatory for all Inventors with respect to all Inventions conceived solely by an Inventor, or made jointly by an Inventor with others. All such disclosures shall be received by the TTO in confidence except as required by law, regulation or ordinance.
- c. An agreement that assigns Inventions and all intellectual property rights related thereto to Cedars-Sinai shall be mandatory for all Inventors except with respect to any Inventions for which no Cedars-Sinai equipment, supplies, facilities or trade secret information was used and which was developed entirely on the Inventor's own time and which does not relate to (i) the business of Cedars-Sinai, (ii) Cedars-Sinai's actual or demonstrably anticipated research or development, or (iii) any work performed by the Inventor for, at or with Cedars-Sinai. For purposes of this Section, the TTO shall make all decisions with respect to the relationship between an Inventor's Invention and his or her employment at or other relationship to Cedars-Sinai. When required by the TTO pursuant to this Section, an Inventor shall execute such further releases in favor of and assignments to Cedars-Sinai with respect to Inventions and any related intellectual property rights as may be required. Inventors who receive funding under Cedars-Sinai agreements with governmental or other third party sources (e.g., research contracts, grants, service industry agreements and grants, service industry agreements and special state appropriations) shall take all actions (including assignments of Inventions and related intellectual property rights) required by the particular agreement or Cedars-Sinai to enable Cedars-Sinai to fully discharge all of its obligations thereunder whether express or implied. (Invention Agreement, see *Related Documents*.)
- d. Subject to such equitable considerations, principles or obligations which the TTO may deem applicable to any particular Invention, the TTO is directed to consider the allocation of a percentage of the "net cash proceeds" (as defined below) actually received by Cedars-Sinai to the Inventor(s) of each Invention, as shall be determined by the TTO, in its sole and exclusive discretion, and shall be approved by the President of Cedars-Sinai or his designee. If no other equitable consideration, principle or obligation is deemed by the TTO to be applicable, it shall be the intention of the TTO (which intention shall not be binding upon the TTO or Cedars-Sinai in any case) to allocate to the Inventor(s), in the aggregate, an amount equal to fifty percent

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(50%) of the first \$2.5 million of net cash proceeds, if any, as and when actually received by Cedars-Sinai with respect to the Invention involved. Once cumulative net cash proceeds has exceeded \$2.5 million, the maximum allocation to the Inventor(s) shall be thirty (30%) of the net cash proceeds, if any, as and when actually received by Cedars-Sinai with respect to the Invention involved.

- 1) The "net cash proceeds" with respect to any Invention shall be determined by the TTO on a cash basis, if, as and when received by Cedars-Sinai, after deducting from the gross proceeds if, as and when received by Cedars-Sinai from such Invention, the full amount of the following items: (i) all expenses incurred by Cedars-Sinai related to such Invention, including, but not limited to, bookkeeping and accounting costs; attorneys', consulting and experts' fees and costs; application, filing, registration and search fees and costs; costs of litigation and settlement; travel expenses; funds expended by Cedars-Sinai or the TTO to enhance the patentability or marketability of the Invention; (ii) all other costs and expenses incurred by Cedars-Sinai in connection with the licensing, sublicensing, manufacturing, marketing and distribution of the Invention, and processing, perfecting and defending the related intellectual property rights and (iii) fifteen percent (15%) of the remaining gross proceeds, which shall be retained by the TTO for its overhead and administrative costs.
- 2) In determining the percentage, if any, of the net cash proceeds in respect of any Invention which may be allocated to the Inventor or Inventors thereof, the TTO is directed, without limiting the scope of its discretion, to consider and weigh the specific employment requirements of the Inventor's employment at or by Cedars-Sinai. The TTO shall further consider all other related factors, such as the interest, if any, that any funding source may have in or to the Invention, or proceeds thereof or the intellectual property rights therein. The TTO may determine that no or a limited allocation should be made to an Inventor based on the relationship between the Inventor's Invention and the specific requirements for which the Inventor is employed or engaged at Cedars-Sinai. For example, if an Inventor is employed or otherwise engaged by Cedars-Sinai to develop computer programs, and in connection therewith develops a specific computer program for which the Inventor seeks additional compensation as an Invention hereunder, no allocation beyond the Inventor's salary should be awarded unless the TTO, in its sole discretion, determines that the Invention deserves extraordinary reward or recognition.
- 3) To the extent that Cedars-Sinai agrees to receive equity in a company in full or partial consideration for rights granted to an Invention or any related intellectual property rights, then such equity will only result in "net cash proceeds" if and when such equity is sold by Cedars-Sinai for cash, if ever. Notwithstanding the provisions of the previous sentence, Cedars-Sinai shall have the right, but not the obligation, in its sole discretion, to offer to buy-out the potential interest of one or more of the Inventors in the possibility of future net cash

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proceeds from the sale of such equity. In instances where Cedars-Sinai purchases equity in a company for consideration other than rights to an Invention or related intellectual property rights, then neither that equity nor any cash that may ultimately be received by Cedars-Sinai upon the sale of the equity shall result in any net cash proceeds that would be shared with any Inventor. In addition, to the extent an Inventor or any member of his or her family receives equity, as a founder or otherwise, in a company in which Cedars-Sinai holds an equity interest in full or partial consideration for rights granted to an Invention or any related intellectual property rights, then Cedars-Sinai's equity or any cash that may ultimately be received by Cedars-Sinai upon the sale of its equity shall not result in any net cash proceeds that would be shared with that Inventor.

- 4) The TTO shall provide the Inventor(s) with Cedars-Sinai's standard royalty sharing agreement, as may be modified from time to time, for the purposes of memorializing the terms and conditions of the distribution of the Inventor(s)' allocable share of net cash proceeds. Following the Inventor(s)' execution of the royalty sharing agreement, the distribution of the Inventor(s)' allocable share of net cash proceeds shall be made at least annually, from the proceeds received by Cedars-Sinai during the preceding twelve (12) month period. In the event of any litigation, pending or threatened, or any other action affecting the Invention, any related intellectual property rights or any claim related to this Policy or the applicability thereof, Cedars-Sinai may withhold distribution and retain all net cash proceeds until final resolution of the matter.

e. First consideration will be given to support scientific research or education in the disposition of any net proceeds received by Cedars-Sinai under this Policy, although such consideration shall in no way obligate or bind Cedars-Sinai to utilize all or any portion of such proceeds for this purpose, and Cedars-Sinai shall have no liability to any party should Cedars-Sinai, in its sole and exclusive discretion, determine not to use such proceeds for this purpose.

Related Documents: Invention Agreement (See attachment on top)

KB0015127 - Latest Version

👤 Revised by Mike Spasoff · 📅 2y ago · 👁 42 Views · ★★★★★

POLICY



Title: Dress and Personal Appearance Policy

Home Department: Human Resources/Organization Development

Effective Date: July 18, 2018

Last Review Date: 01/09/2018

IMPORTANT NOTICE:

The official version of this document is contained in the HR Service Center website and may have been revised since the document was printed.

I. Scope

This policy applies to all employees of Cedars-Sinai Medical Center and Cedars-Sinai Medical Care Foundation (referred to as “Cedars-Sinai”), contract and registry personnel and others assigned to work at Cedars-Sinai.

II. Policy Statement(s)

Cedars-Sinai is committed to excellence in delivering quality health care services. Patient care and safety remain top priorities at Cedars-Sinai.

A key component of how our customers perceive the quality of service we render is the personal appearance of each employee. Additionally, patient and employee safety considerations may drive more rigorous standards and requirements in certain departments.



Dress and personal appearance must be professional and consistent with Cedars-Sinai's business environment atmosphere and fulfill the unique requirements characteristic of the health care industry.

III. Purpose

The purpose of this policy is to establish rules, expectations and standards designed to meet these objectives.

IV. Definitions of Key Terms and Concepts

There are no applicable terms, concepts or definitions associated with this policy.

V. Policy Applicability and Requirements

Employees covered by a collective bargaining agreement ("CBA") should refer to their CBA. In the event of a conflict between this policy and the CBA, the CBA controls.

Supervisory Responsibilities

All supervisory personnel for Cedars-Sinai are responsible for the following:

- Clearly communicating Cedars-Sinai's dress and personal appearance standards to those covered by this policy;
- Serving as role models in their own dress and personal appearance; and
- Consistently and fairly enforcing this policy.

Department Directors are responsible for oversight and enforcement of departmental dress and personal appearance standards. This includes the establishment of appropriate expectations for uniformed employees if uniforms supplied by Cedars-Sinai are not available for any reason (e.g. for new or temporary employees) and for assuring that registry, contract personnel and others who may be covered by this policy are aware of and comply with these standards.

General Requirements and Standards - All Locations and Positions

General requirements apply to all individuals covered by this policy, whenever on duty, regardless of where they are assigned and including times when working and/or attending training sessions outside their regular work areas. When attending meetings or training sessions in locations other than their regular work location, dress standards may be more casual or less casual, depending on the event and location. Employees should check with their managers or meeting facilitators regarding appropriate attire.



Identification Badges

All personnel must wear position/job-appropriate Cedars-Sinai provided identification name badges displayed above the waist while on duty.

Shoes and Hosiery/Socks

Socks shall always be worn when working in clinical or patient care areas. Shoes shall be worn in all areas. Shoes, as part of a required uniform, are to be compatible with the uniform itself.

Dress or professional-style shoes, are to be worn by office employees. Sling-back shoes (with straps across the heel) and open-toe shoes (not including sandals – see list below) are acceptable in an office environment but not in a clinical or patient care setting. Athletic shoes may not normally be worn in an office environment, unless there is a medical reason to do so. Whenever they are worn, they must be tied.

Personal Grooming and Hygiene Standards

Expectations for personal grooming and hygiene standards are set forth in this policy. These standards are to be maintained whenever on duty by all individuals covered by this policy. Standards include:

- Personal cleanliness and hygiene, including but not limited to bodily, oral and hand hygiene, are to be maintained. Employees may provide medical certification and seek accommodation for conditions that may present as personal hygiene problems.
- Hair must be neat, clean, and well-trimmed. Hair styles may not be extreme or serve as a distraction to others. Hair nets or scrub caps, for either health or safety reasons, are to be worn when necessary or prescribed by law.
- Facial hair is acceptable but must be neat, clean and well-trimmed.
- Cosmetics are acceptable, although heavily scented colognes, perfumes, deodorants, lotions or other products are to be avoided, particularly in patient care areas. Make-up should not be extreme or distracting and should be work-appropriate.
- Fingernails are to be kept neat in appearance and clean. Nail length should not be so excessive as to inhibit ability to effectively perform all work functions, cause frequent breaking or possible injury, or serve as a distraction to others.
- Employees working in direct patient care or in areas where it is otherwise prohibited, may not wear artificial nails, including but not limited to acrylic nails, gel nails and wraps, in accordance with established organizational and departmental policies, guidelines or practice. Certain areas may also prohibit the wearing of nail polish, including clear polish.
- Employees may be required to cover tattoos while at work.

Condition of Work Attire

All clothing must be clean, neatly pressed and in good repair when reporting to work. This applies to individual personal wardrobe items as well as uniforms, scrubs, lab coats or any attire, including hospital-provided items. Shoes are to be clean, in good repair and work-



appropriate.

Restrictions to Work Attire and Accessories

Jewelry and other accessories shall be work-appropriate and may not be worn where safety or health standards would be compromised.

Generally prohibited are casual, recreational, provocative or otherwise extreme clothing, regardless of current fashion trends or individual body type. Examples of such clothing, accessories or styles include, but are not limited to the following:

- T-shirts
- Sweat shirts or sweat suits
- Work-out wear
- Shorts
- Leggings
- Denim
- Mini-skirts/dresses, including those that “hike up” when sitting
- Excessively tight clothing
- Excessively loose or baggy clothing
- Tube and tank tops
- Low-cut or otherwise revealing blouses or tops
- Clothing that reveals a bare midriff
- Bare-shoulder garments, including halter tops or those with thin or spaghetti-straps
- Open-shoulder blouses
- See-through garments
- Exposed undergarments
- Personal audio headphones, ear buds, phone earpieces or other similar devices
- Sunglasses worn indoors
- Hats, except for safety reasons
- Sweatbands or kerchiefs used as headwear
- Flip-flops
- Sandals (e.g. strap(s) across top of foot with toes exposed), including sandals with heels
- Shoes that are excessively high or that may otherwise render walking difficult or unsafe
- Any clothing, accessory or other item that may compromise safety

Standards for Required and Acceptable Work Attire

The criteria for professional dress at Cedars-Sinai as established in this policy shall be considered standard in all areas unless, by location, a modified standard is approved.

Medical Center Standard for Professional Attire



Employees working in the Medical Center Campus, in surrounding professional office settings or who may, in the course of their work, have contact with patients and visitors to Cedars-Sinai are expected to wear professional business attire, in keeping with community standards. Examples of this are “dress” shirts, neckties and slacks or suits for men, and “dress” skirts, blouses, slacks, dresses and suits for women.

Denim clothing (or “jeans”) is not acceptable in this environment. However, rare exceptions may be approved by the appropriate Vice President or his/her designee, if appropriate, based upon the type of work being performed, worksite/location and in keeping with customer expectations (for example, jeans may be appropriate during departmental relocations).

Employees Wearing Lab Coats or Non-Uniformed Employees Working in Direct Patient Care

Employees wearing lab coats or non-uniformed employees working in direct patient care areas are expected to comply with the general requirements for all employees indicated above. This includes standards for work clothing under lab coats.

Lab coats must be clean, neatly pressed and in good repair when reporting to work. Lab coats may not bear the name or insignia of any institution other than Cedars-Sinai.

Uniformed Employees

Uniforms, as prescribed by the department or Medical Center, such as color-coordinated scrubs or uniforms provided under Cedars-Sinai’s Visual Identification by Profession (“VIP”) Program, must be worn while on duty. Only uniforms provided by Cedars-Sinai or purchased from the authorized vendor may be worn. They must be clean, neatly pressed and in good repair when reporting to work.

If the required uniform is unavailable for any reason (such as for new or temporary employees), employees are expected to comply with general requirements for all employees, cited above, and any departmental guideline that may be available for such circumstances.

Uniforms issued and laundered by Cedars-Sinai are to be turned in for cleaning on a routine and timely basis.

Uniforms may not bear the name or insignia of any institution other than Cedars-Sinai. Uniform pins and badges may be worn and may include professional association pins or emblems, and service award pins.

Other Non-Uniformed Employees



Other non-uniformed employees are expected to comply with the general standards indicated for all employees cited above.

Off-Campus Department Standards for Work Attire

Requirements for work attire may vary in work locations not located on the Medical Center Campus. Such variation may also be based on department, work environment, type of work performed, potential for contact with patients or visitors or other factors. In such situations, specific standards for acceptable attire may be established with approval from the appropriate Vice President or his/her designee. For purposes of this policy, such requirements are known as department standards. Established department standards for attire may be more rigorous or less rigorous than the policy standards for work attire outlined above. Department standards, where they exist, must be observed. In the absence of established department standards, or on occasions when employees will be in areas visible to patients or visitors such as to attend meetings, Cedars-Sinai's standards for professional attire will apply.

Non Compliance

Employees who do not comply with dress code and personal appearance policies (both organizational and/or departmental) may be asked to leave work and return only when properly attired. In such instances, non-exempt staff will not be paid for time lost due to this requirement. They will also be subject to corrective action which may culminate in termination of employment.

VI. Policy Exceptions

Department Directors may implement modifications within the parameters outlined in this policy as consistent with the operational needs of their areas. Such modifications may never compromise safety or quality of patient care and are subject to approval by the appropriate Vice President.

Religious or Medical Accommodations

Individuals who may have difficulty complying with any of requirements of this policy for medical or religious reasons should speak to their manager to request a reasonable accommodation.

Bona fide religious garments may be worn in lieu of required uniforms or business attire, but must be clean, neatly pressed, and in good repair when reporting for work.

VII. Related Policies

- Dress and Personal Appearance Policy - Patient Accounting
- Dress Code and Personal Appearance Policy - Health Info. Dept.
- Dress Code for Uniform and Non-Uniform Policy - Admissions



- [Corrective Action - Non-Bargaining Unit Policy](#)
- [Corrective Action - Bargaining Unit Policy](#)

VIII. Related Forms and Resources

- [Scrubs Color Chart](#)

IX. References

There are no applicable references associated with this policy.

X. Questions

For questions about this or any HR policy, please call myHR at 1-833-CS4-MYHR or extension 4-MYHR.

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Title: California Medical Licensure Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

The official version of this Policy is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.

I. POLICY

It is the policy of Cedars- Sinai Medical Center that all physicians-in-training possess a valid California license to practice in their field of medicine or a Postgraduate Training License as required by state law.

- A. Requirements for allopathic (MD) or osteopathic (DO) physicians-in-training:
1. Except as noted in I.A.3. below, MD and DO physicians-in-training must possess a valid State of California full and unrestricted medical license as prescribed by law if they have completed thirty-six (36) months of postgraduate medical training in an ACGME-approved program. Applicants have a ninety (90) day grace period to obtain a medical license after enrollment in an ACGME-accredited program.
 2. Except as noted in I.A.3 below, MD and DO physicians-in-training who have not completed 36 months of postgraduate medical training in an ACGME-approved program must obtain a valid State of California Postgraduate Training License (PTL) within 180 days after enrollment in an ACGME-accredited postgraduate training program in California in order to practice medicine as part of their training program. PTLs will be valid until ninety (90) days after the trainee has successfully completed the required training if the physician-in training is continuing in an ACGME-accredited program.
 3. Rotators to CSMC from other ACGME-approved programs sponsored by out-of-state institutions may train at CSMC without possessing a valid state of California medical license if all of the following criteria are met:
 - a. The total of all rotations lasts no more than 90 days.
 - b. Rotator is coming to an ACGME-approved training program.
 - c. Rotator graduated from a school listed on the World Directory of Medical Schools. The list of approved medical schools can be found at <https://wdoms.org>.
 - d. Rotators register with the California Medical Board as a visiting resident/fellow (i.e., listed as "guest physician" on the California Medical Board Postgraduate Training Registration Form).
 4. For all physicians-in-training participating in non-ACGME fellowships, and all physicians-in-training participating in programs requiring that the physician-in-training be granted Cedars-Sinai medical staff privileges, the California license required by law must be subject to no current disciplinary actions, including without limitation, suspension or probation.
- B. Podiatry physicians-in-training must possess a valid resident's license issued by the California Board of Podiatric Medicine (BPM) before participating in a BPM-approved

Title: California Medical Licensure Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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postgraduate podiatric residency training program. The resident's license must be renewed annually and is required even if the trainee has a full DPM license.

C. Verification of licensure status:

1. The currency of physician-in-training medical licenses or PTLs must be verified via direct confirmation from the official licensing website. For MD physicians, this information is available from www.mbc.ca.gov (choose "License Search"). For DO physicians and podiatrists, this information is available from www.breeze.ca.gov (choose "License Search").
2. Documentation of licensure is included in the physician-in-training's record in New Innovations.

II. PURPOSE

To ensure that all physicians-in-training at CSMC are in compliance with State of California licensure requirements.

III. DEFINITIONS / RESPONSIBILITIES

- A. ACGME-approved program: Those postgraduate training programs that are accredited by either the Accreditation Council for Graduate Medical Education (ACGME), Royal College of Physicians and Surgeons of Canada (RCSPC) or College of Family Physicians of Canada (CFPC) that includes four months of general medicine.
- B. It is the responsibility of the physician-in-training to obtain and maintain California licensure or PTL as required by law to practice medicine within the scope of their training program and in accordance with their Physician-in-Training Agreement.

IV. POLICY APPROVAL(S)

Graduate Medical Education Committee: January 7, 2020

Mark S. Noah, MD

Associate Dean, Medical Education

Designated Institutional Official

Original Effective Date: 01/01/09

Title: Cedars-Sinai Employee Policy for Personal Social Media Use: Marketing and Communications Department

Home Department: Marketing and Communications Department

IMPORTANT NOTICE:

The official version of this document is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.

I. SCOPE

This policy applies to all employees of Cedars-Sinai Medical Center and Cedars-Sinai Medical Care Foundation ("Cedars-Sinai"), as well as faculty, physicians who are employed as part of the medical network, all students and trainees, temporary and agency personnel, interns, volunteers, faculty, and physicians on the medical staff (collectively referred to herein as "individuals" or "covered individuals").

II. POLICY STATEMENT

The purpose of this policy is to provide Cedars-Sinai individuals covered by this policy with requirements for participation in personal social media in which the individual's Cedars-Sinai affiliation is known, identified or presumed. It applies to the use of social media while at work and when away from work when the individual's Cedars-Sinai affiliation is known, identified, or presumed.

Nothing in this or other Cedars-Sinai policies is intended to restrict employees' rights to discuss wages and working conditions or otherwise engage in protected activity.

The purpose of this policy is to establish rules for and provide guidance regarding the types of social media communications and/or actions that may be considered grounds for discipline up to termination of employment or suspension from your volunteer or educational program.

III. GUIDELINES

Individuals covered by this policy who participate in social media must adhere to the following guidelines:

Title: Cedars-Sinai Employee Policy for Personal Social Media Use: Marketing and Communications Department

Home Department: Marketing and Communications Department

IMPORTANT NOTICE:

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- **Follow All Policies.** All rules that apply to other Cedars-Sinai communications apply to social media as well, specifically: Respect patients, customers and one another; protect confidentiality, privacy and security; and safeguard proper use of Cedars-Sinai assets. Know and follow all applicable Cedars-Sinai policies. Policies most relevant to this discussion include General Expectations Policy, Equal Employment Opportunity Policy, Confidentiality of Patient, Business and Employee Information Policy: Corporate Integrity Program, Filming/Taking Pictures/Voice Recording of Patients and Health System Employees Policy, and Discharge Without Prior Corrective Action Policy and any applicable federal or state laws. It is most critical that employees not share confidential or proprietary information about Cedars-Sinai and that they maintain patient privacy at all times.
- **Protected Health Information.** Covered individuals are prohibited from posting any content that is protected health information (PHI), including patient images, details or stories, or information from medical records, on any social media site unless it has been shared on the Cedars-Sinai public website or on the primary Cedars-Sinai social media sites named @CedarsSinai. See the Confidentiality of Patient, Business, and Employee Information Policy for a list of PHI. Do not respond to online reviews or other comments regarding care received at Cedars-Sinai. Anything that could be construed as confirming someone's status as a patient may be a violation of HIPAA.
- **Medical Advice.** Do not give specific medical advice online. Giving general information relevant to one's specialty is fine, but if someone wants explicit medical information or advice, direct them to make an appointment with their doctor. Do not provide "one-to-one" health advice on social media sites.
- **Cedars-Sinai Brand Identity.** Individuals may tag @CedarsSinai in their social media bios, but use of Cedars-Sinai's name or intellectual property in any handle or profile picture is prohibited. Individual social media names, handles, or URLs may **not** use the Cedars-Sinai name, department, program or logo. For example, @CedarsDoc would **not** be an appropriate handle. Use of logos, trademarks, graphics or other intellectual property that could create the appearance that an individual not expressly authorized to do so is speaking on behalf of Cedars-Sinai is prohibited.
- **Cedars-Sinai Affiliation.** If a covered individual identifies his/her affiliation to Cedars-Sinai, all social media activities should be consistent with the Cedars-Sinai's high standards of professional conduct. Where any connection to Cedars-Sinai is apparent, the individuals must

Title: Cedars-Sinai Employee Policy for Personal Social Media Use: Marketing and Communications Department

Home Department: Marketing and Communications Department

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make it clear that they are speaking only for themselves and not on behalf of Cedars-Sinai or its affiliates.

- **Endorsing Cedars-Sinai.** Any covered individual who endorses Cedars-Sinai products or services, or those of Cedars-Sinai's affiliates, on social media must identify him/herself as being affiliated with Cedars-Sinai, stating his/her specific role and making it clear that such endorsement is made on his/her own behalf only.
- **Personal Responsibility.** Cedars-Sinai employees are personally responsible for the content they publish or post online.
 - **Social Media is Public.** Individuals should be mindful that what they publish may be available for public view indefinitely. Additionally, such information may be considered public knowledge, so protecting one's own privacy may also be a concern. They must keep in mind that even messages sent privately can become and remain public. For this reason, it is important to protect privacy and understand each site's terms of service and privacy policies before posting content to these sites. Individuals must use a personal email account for their social media activities. Use of a Cedars-Sinai email address for personal social media is prohibited.
 - **Exercise Good Judgment.** When individuals are speaking for themselves, they should keep in mind that their actions may reflect on Cedars-Sinai. They should always be professional, use good judgment, and be accurate and honest in their communications, in accordance with Cedars-Sinai's policies.
 - **Be Respectful.** Remember that Cedars-Sinai patients and employees reflect a diverse set of customs, values, backgrounds and points of view. Individuals covered by this policy should consider Cedars-Sinai's workplace standards for respect and professionalism as well as our prohibitions against inappropriate behavior, harassment, discrimination, use of profanity and racial or ethnic slurs, bullying, intimidation and retaliation. When an individual's affiliation with Cedars-Sinai is apparent on social media, posts by that individual reflect on Cedars-Sinai.
 - **Work Responsibilities.** Covered individuals should be conscientious when mixing business and personal life. They must ensure that social media activity does not interfere with work commitments.

POLICY



Effective Date: 10/28/2020

Title: Cedars-Sinai Employee Policy for Personal Social Media Use: Marketing and Communications Department

Home Department: Marketing and Communications Department

IMPORTANT NOTICE:

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Have a question, ideas, or a request? Please contact the Social Media Department at socialmedia@cshs.org.

For general conduct guidelines, please ensure your online presence aligns with Cedars-Sinai's "General Expectations Policy."

As a reminder, upon hire, Cedars-Sinai employees enter a partnership with all other members of the organization to maintain the highest level of job performance and professional decorum, and they are expected to foster the mission, goals, business interests and reputation of the organization. Interactions with all Cedars-Sinai's patients, visitors, employees, physicians, or any other individuals must be conducted with courtesy, respect, and dignity.

Employees who do not act in accordance with these and other Cedars-Sinai or department policies, procedures or standards of conduct are subject to corrective action, up to and including termination of employment.

Nothing in this or other Cedars-Sinai policies is intended to restrict employees' rights to discuss wages and working conditions or otherwise engage in protected activity.

IV. RELATED POLICIES

- Filming/Taking Pictures/Voice Recording of Patients and Health System Employees Policy
- Confidentiality of Patient, Business, and Employee Information Policy
- Discharge Without Prior Corrective Action Policy
- General Expectations Policy
- CSHS Information Security Handbook
- Equal Employment Opportunity

V. POLICY APPROVALS

Name, Title, Department

POLICY



Effective Date: 10/28/2020

Title: Cedars-Sinai Employee Policy for Personal Social Media Use: Marketing and Communications Department

Home Department: Marketing and Communications Department

IMPORTANT NOTICE:

The official version of this document is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.

Original Effective Date: _____

Title: Filming/Taking Pictures/Voice Recording of Patients and Health System Employees of the Health System Policy: Corporate Integrity Program

Home Department: Corporate Integrity Program/HIPAA Compliance

Document Owner: Ashna Bhardwaj (Manager)

IMPORTANT NOTICE:

The official version of this document is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.

I. POLICY

Photographing or filming of patients or Cedars-Sinai Health System ("CSHS") employees (including filming through electronic devices such as digital cell phone cameras) and voice recording of patients and CSHS employees ("Filming/Recording") is permitted only under specified circumstances or with the patient's or staff's prior written consent.

This policy does NOT cover Filming/Recording done at non-CSHS sponsored events unless the Filming/Recording is done by CSHS employees for use by the CSHS.

This policy does not cover patients' requests for Filming/Recording or Filming/Recording of patients by family members. Such requests should be referred to Administration. However, in no event shall such filming/recording be permitted if it will interfere with the CSHS's operations, services to its patients, or patient privacy and security.

II. PURPOSE

To ensure that patient safety and the right of privacy for patients and staff are maintained.

III. PROCEDURE

A. Photographing or filming of patients or CSHS employees (including filming through digital cell phone cameras) and voice recording of patients or CSHS employees ("Filming/Recording") is permitted without prior written consent only under the following circumstances:

1. By CSHS staff for
 - a. Medical education and training
 - b. Security purposes (e.g., security cameras)
 - c. Treatment, forensic or diagnostic purposes
 - d. Use of employee pictures/recordings in accordance with Paragraph D below.
2. By CSHS staff pursuant to the Medical Center Conditions of Admissions.
3. By families in the Obstetrical Service pursuant to Photographs/Videotaping Obstetrical Service Policy (PPP00004).
4. By law enforcement for identification purposes of DOE patients.

Title: Filming/Taking Pictures/Voice Recording of Patients and Health System Employees of the Health System Policy: Corporate Integrity Program

Home Department: Corporate Integrity Program/HIPAA Compliance

Document Owner: Ashna Bhardwaj (Manager)

IMPORTANT NOTICE:

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- B. Other than for the specific circumstances enumerated in Paragraph III.A above which do not require prior written consent, all Filming/Recording requires the patient's prior written consent.
- C. Filming/Recording of patients for research purposes requires prior written consent of the patient (or the patient's legal representative as applicable).
- D. When employees are filmed/recorded for use by CSHS Communications Department pursuant to the Communications Department Policy (ADM00035), verbal consent is sufficient.
- E. At no time may the permitted Filming/Recording include any other patients and/or CSHS employees **without their individual prior written consent**.
- F. Patients who are under duress, acutely ill or injured, mentally impaired, intoxicated, in custody or in acute grief, anguish or pain, shall not be approached for consent for Filming/Recording.

Exception: See Psychiatry Policy for Filming/Recording (C-5)

- G. Requests for Filming/Recording of patients for “**commercial purposes**” must be approved by the Vice President of Communications, the Vice President of Service Line Operations, the Vice President of Academic Affairs, the physician of record, the Chairman of the Department, and the Vice President of Nursing along with prior written consent and HIPAA authorization from any patients and all others involved in the care of the patients who may be included in the Filming/Recording. Staff has the right to refuse to participate in the Filming/Recording sessions.
- H. If the patient's written consent is required, it shall be obtained in advance of any Filming/Recording and must:
 - 1. Identify all persons who will be present during the Filming/Recording
 - 2. Explain any additional potential risks to the patient
 - 3. Be obtained by a disinterested third party, and not by a member of the production team or by any other party who may directly benefit financially or otherwise from the filming
- I. Stopping the Filming/Recording
 - 1. The patient has the right to have Filming/Recording stopped at any time and may also, with the exception of footage being taken by a news media outlet, revoke their consent and HIPAA authorization at any point until the Filming/Recording is completed.

Title: Filming/Taking Pictures/Voice Recording of Patients and Health System Employees of the Health System Policy: Corporate Integrity Program

Home Department: Corporate Integrity Program/HIPAA Compliance

Document Owner: Ashna Bhardwaj (Manager)

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2. Any person involved in the direct medical care of the patient who feels that Filming/Recording may jeopardize patient care can require that the film crew be removed immediately from the patient care area.
 3. Staff has the right to refuse to participate in filming sessions.
 4. Neither patients, patient representatives, nor patient family members are permitted to conduct Filming/Recording of employees without express employee consent.
- J. Members of the Filming/Recording team who are not members of the healthcare team must sign and adhere to the institutional confidentiality agreement as required by CSHS policy.
- K. If a staff member encounters any Filming/Recording that does not meet the above guidelines, the staff member should ask the person(s) doing the Filming/Recording to discontinue that activity immediately. The manager should be notified of unauthorized filming/recording.
- L. If a cell phone or digital camera is used as the filming/photography medium, staff should request that all pictures be deleted from the cell phone/camera before the user takes the cell phone/camera off campus. If the person filming refuses to delete the pictures, Security and Risk Management should be called immediately.
- M. Any request by law enforcement other than that described in paragraph III.A.4 above is to be referred to Risk Management.

IV. REFERENCES/RELATED POLICIES

- A. California Healthcare Association *Consent Manual*, current version
- B. Community Volunteer or Visitor (ADM00150)
- C. Confidentiality of Patient, Business and Employee Information (Policy and Acknowledgement form; EBE00008)
- D. Consent for Patient Photography and Publishing (Form #6562)
- E. Consent for Photography/Audio-visual Recording of Psychiatry Patients (Policy C-5)
- F. Domestic Violence: Spousal/Partner Abuse (EBE00007)
- G. Elder/Dependent Adult Abuse or Neglect, Suspected (EBE00004)

Title: Filming/Taking Pictures/Voice Recording of Patients and Health System Employees of the Health System Policy: Corporate Integrity Program

Home Department: Corporate Integrity Program/HIPAA Compliance

Document Owner: Ashna Bhardwaj (Manager)

IMPORTANT NOTICE:

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- H. [Discharge Without Corrective Action: Human Resources](#)
- I. Photographs/Videotaping Obstetrical Service (PPP00004)
- J. Preoperative/Preprocedure Preparation and Testing (CCN00114)
- K. Pressure Dermal Ulcer: Care of Patient With (CCN00076)
- L. Psychiatry Policy for Filming/Recording (C-5)
- M. Public Relations Department (ADM00035)

V. POLICY APPROVALS

Linda Burnes Bolton, Dr.P.H., RN, FAAN
Vice President and Chief Nursing Officer

Richard Elbaum
Vice President, Communications and Marketing

Original Effective Date: February 2009

Title: Moonlighting and Other Outside Professional Activities Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

The official version of this Policy is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.

I. PURPOSE/POLICY STATEMENT:

- A. This policy applies specifically to physicians-in-training who are enrolled in CSMC ACGME-accredited graduate medical education programs.
- B. This policy provides guidelines on, and establish limits to, resident/fellow participation in outside professional activities, in accordance with ACGME institutional and program requirements.
- C. In order to assure that Physicians-in-Training are rested and alert while engaging in program activities, Moonlighting, as defined below, is discouraged. (For policy regarding outside educational activities, see GME Policy "Conferences and Other Outside Educational Activities.")

II. DEFINITIONS:

- A. "External moonlighting" as such term is used herein, shall mean any voluntary, compensated, unsupervised, medically-related work outside Cedars-Sinai Medical Center.
- B. "Extra Pay for Extra Shifts" as such term is used herein shall mean extra clinical duties that occur within the scope of the Physician-in-Training's program and are supervised, but that are performed outside the Physician-in-Training's regularly scheduled duties or required responsibilities, and that are assumed by the Physician-in-Training on a voluntary basis for additional compensation at Cedars-Sinai Medical Center. The definitions of supervision levels can be found in the [Housestaff Supervision policy](#).
- C. "Internal Moonlighting" as such term is used herein, shall be deemed to mean any voluntary, compensated, medically-related work (not related to training requirements) performed as a licensed independent practitioner within Cedars-Sinai Medical Center in an outpatient or Emergency Department area.
- D. "Moonlighting" as such term is used herein encompasses both External Moonlighting and Internal Moonlighting.

III. POLICY:

- A. Moonlighting
 1. No Physician-in-Training shall be required to engage in Moonlighting.
 2. Permission for Moonlighting:
 - a. Participation in any Moonlighting must receive prior written approval from the Program Director. (See Appendix A for the required form.)

Title: Moonlighting and Other Outside Professional Activities Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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- b. A copy of the written acknowledgment must be retained in the Physician-in-Training departmental file.
 - c. The Physician-in-Training's performance will be monitored by the Program Director for the effect of Moonlighting upon his/her performance.
 - d. The Program Director may prohibit Moonlighting or withdraw permission for Moonlighting upon notice of adverse effect of Moonlighting activities on the Physician-in-Training's performance.
3. Restrictions on Moonlighting Activity:
- a. Program Directors have the authority to deny requests for Moonlighting for any reason in their discretion including, without limitation, because Moonlighting may adversely impact the Physician-in-Training's performance at the Medical Center.
 - b. Time spent Moonlighting by the Physicians-in-Training must be counted towards the 80-hour weekly duty hour limit. Physicians-in-Training may not engage in Moonlighting which would increase his or her total involvement in patient care activities (including training-related patient care activities) to a level that violates duty hour limits, as given in GME Policy "Housestaff Duty Hours and On-Call Schedules," or otherwise conflicts with the requirements of the program's accrediting agency.
 - c. Physicians-in-Training may not engage in Internal Moonlighting in any inpatient setting at Cedars-Sinai Medical Center. Internal moonlighting is only permitted in outpatient licensed areas of Cedars-Sinai Medical Center and in the Emergency Department, as long as such Internal Moonlighting is outside the medical specialty of the Physician-in-Training's current training program.
 - d. J-1 visa holders are prohibited from Moonlighting. H-1B visa holders are also prohibited from Moonlighting unless specifically allowed in their visa.
4. Liability coverage and qualifications:
- a. A Physician-in-Training who engages in Moonlighting, should ensure he or she has professional liability coverage for the period(s) in which he or she is engaged in the activity. Liability coverage provided by the Medical Center for training-related activities shall not be in effect during Moonlighting.
 - b. A Physician-in-Training who engages in Moonlighting must be licensed for unsupervised medical practice in the state where the Moonlighting occurs.

Title: Moonlighting and Other Outside Professional Activities Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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- c. It is the responsibility of the Physician-in-Training and the institution hiring the “moonlighter” to determine whether appropriate licensure, liability coverage and training/skills are in place to carry out assigned Moonlighting duties
5. Billing for Moonlighting
 - a. Internal Moonlighting
 - i. Internal Moonlighting services may be performed and billed *if all* the following conditions are met:
 - a) The services are furnished in the outpatient or emergency department of Cedars-Sinai;
 - b) Appropriate Medical Staff Privileges are applied for and granted in advance.
 - c) The services are not related to the Physician-in-Training's approved GME program and the time involved is not counted by the hospital for purposes of its GME payments; and
 - d) The services are furnished pursuant to a contract that requires that:
 - The Physician-in-Training is fully licensed to practice under the law of the State of California;
 - The services are identifiable services to individual patients that qualify as billable physician services;
 - The services can be separately identified from services that are required for the Physician-in-Training GME program.
 - ii. The billing office shall be provided with a copy of each such contract in order to furnish it to the Medicare Part B carrier before billing for the Internal Moonlighting Physician-in-Training services.
 - b. External Moonlighting services that are furnished outside of Cedars-Sinai Medical Center (e.g., in physician offices, nursing homes, other hospitals) are not considered to be part of the Program and may be separately reimbursable to the Physician-In-Training as physician services, subject to all applicable coverage and reimbursement rules and regulations. Time spent in external moonlighting activity must not be claimed as an allowable rotation within IRIS (New Innovations).
- B. Extra Pay for Extra Shifts
 1. Extra Pay for Extra Shifts is not considered Moonlighting as it is considered to be a component of the resident or fellow's training, however, the time spent on such activity must be counted towards the 80-hour weekly duty hour limit.

Policy



Effective Date: 01/26/2022

Title: Moonlighting and Other Outside Professional Activities Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

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2. A Physician-in-Training shall not be required to participate in Extra Pay for Extra Shifts.
3. Participation in Extra Pay for Extra Shifts must receive prior written approval from both the Physician-in-Training and the Program Director. (See Appendix B for the required form.)
4. A copy of the written acknowledgement must be retained in the Physician-in-Training departmental file.
5. Billing by teaching physicians for supervising Physicians-in-Training for Extra Pay for Extra Shifts is permissible and shall comply with applicable laws, regulations and Cedars-Sinai Medical Center policies.

IV. POLICY APPROVAL(S)

Graduate Medical Education Committee: December 14, 2021

Mark S. Noah, M.D.
Designated Institutional Official
Associate Dean, Medical Education

Original Effective Date: 09/01/08

Attachment "L"

Stipend Amounts

Effective December 19, 2021, physicians-in-training will receive annual base stipends as follows:

GL-1 - \$64,362
GL-2 - \$66,495
GL-3 - \$69,107
GL-4 - \$71,835
GL-5 - \$74,775
GL-6 - \$77,554
GL-7 - \$80,148

H1-B Visa Holder Stipends* (Taken from Table 4 of 2021 AAMC Survey of Resident/Fellow Stipends and Benefits Report – West Region)

1st Post-MD Year - \$61,139
2nd Post-MD Year - \$63,964
3rd Post-MD Year - \$67,215
4th Post-MD Year - \$70,914
5th Post-MD Year - \$74,514
6th Post-MD Year - \$78,529
7th Post-MD Year - \$82,781

*H1-B Visa holders will receive the higher of the two rates

POLICY

Title: Leave of Absence Policy for Physicians in Training: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

Effective Date: 02/25/2019

Last Review Date: 02/25/2019

IMPORTANT NOTICE:

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I. Scope

This policy applies to physicians-in-training within the Academic Affairs / Graduate Medical Education department of Cedars-Sinai Medical Center.

II. Policy Statement(s)

The Medical Center's policies regarding leaves of absence for medical or other reasons complies with applicable laws, including but not limited to the federal Family & Medical Leave Act (FMLA) and the California Family Rights Act (CFRA). This policy provides additional information for physicians-in-training regarding leaves of absence.

III. Purpose

The purpose of this policy is to ensure that physicians-in-training are provided with and informed of leave of absence benefits that meet legal requirements, and to establish standards for the granting and administration of physician-in-training leaves of absences.

IV. Definitions of Key Terms and Concepts

Physician-in-training	A physician enrolled in a graduate medical education program who has completed medical training in (1) a medical school in the United States or Canada accredited by the Liaison Committee on Medical Education, (2) a college of osteopathic medicine in the United States accredited by the American Osteopathic Association, (3) a medical school outside of the United States or Canada recognized or approved by the Medical Board of California and holding a currently-valid certificate from the Educational Commission for Foreign Medical Graduates; OR (4) a graduate of a college of podiatric medicine accredited by the Council on Podiatric Medical Education.
Graduate Medical Education Program	The period of didactic and clinical education in a medical specialty or subspecialty which follows the completion of undergraduate medical education and which prepares physicians for the independent practice of medicine in that specialty or subspecialty. Also referred to as residency or fellowship education.
Resident	A physician-in-training in a graduate medical education program leading to eligibility for primary certification in a medical specialty.
Fellow	A physician-in-training in a graduate medical education program leading to eligibility for secondary or advanced certification in a medical specialty.

V. Policy Applicability and Requirements

A. General

1. While the goal of a physician-in-training is to successfully meet the requirements for Board eligibility, there are circumstances under which a leave of absence from the program is necessary. In such cases, a leave of absence may be provided under one or more of the following Cedars-Sinai policies:
 - [FAMILY CARE AND MEDICAL LEAVE OF ABSENCE POLICY: HUMAN RESOURCES/ORGANIZATION DEVELOPMENT](#)
 - [PREGNANCY DISABILITY LEAVE OF ABSENCE POLICY: HUMAN RESOURCES/ORGANIZATION DEVELOPMENT](#)
 - [EMPLOYEE MEDICAL LEAVE OF ABSENCE POLICY: HUMAN RESOURCES/ORGANIZATION DEVELOPMENT](#)
 - [PERSONAL LEAVE OF ABSENCE POLICY: HUMAN RESOURCES/ORGANIZATION DEVELOPMENT](#)
 - [ORGAN AND BONE MARROW DONOR LEAVE OF ABSENCE POLICY: HUMAN RESOURCES/ORGANIZATION DEVELOPMENT](#)
 - [MILITARY SPOUSE OR DOMESTIC PARTNER LEAVE POLICY: HUMAN RESOURCES/ORGANIZATION DEVELOPMENT](#)
 - [TIME OFF FOR CIVIC RESPONSIBILITIES AND DOMESTIC MATTERS POLICY: HUMAN RESOURCES/ORGANIZATION DEVELOPMENT](#)
2. The specialty Board that governs each physician-in-training determines whether a physician-in-training who takes a leave of absence, whether intermittent or continuous, within the program year is required to make up the time at the end of the program. The Graduate Medical Education Office will notify the physician-in-training as soon as possible once it becomes aware of the need to extend the program for that individual.
3. A physician-in-training is responsible for notifying his/her program director of the need to take a leave of absence as soon as possible and also to keep the program director informed of any changes or modifications to the leave request. Further, it is the responsibility of the program director to ensure that the Graduate Medical Education Office is notified of any leave of absence, including changes or modifications thereto, taken by a physician-in-training.

VI. Policy Exceptions

There are no exceptions to this policy allowed.

VII. Related Policies

See list above.

VIII. Related Forms and Resources

There are no applicable forms or resources associated with this policy.

IX. References

[LEAVE OF ABSENCE PROCEDURES FOR PHYSICIANS-IN-TRAINING: GRADUATE MEDICAL EDUCATION](#)

Policy

Effective Date: 12/02/2019

Title: Well-Being Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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I. POLICY

- A. It is the policy of the Medical Center to encourage and support the well-being of residents/fellows and faculty members.
- B. It is the policy of the Medical Center to facilitate access to appropriate and confidential counseling, medical, and psychological support services for residents/fellows.
- C. It is the policy of the Medical Center to assure a drug-and alcohol-free environment that is safe for residents/fellows, employees, students, patients and visitors.

II. PURPOSE

- A. To ensure that the well-being of all residents/fellows is appropriately monitored and addressed.
- B. To ensure that residents/fellows are provided with access to confidential counseling and behavioral health services.
- C. To ensure that educational programs and information on well-being and self-care are provided to all residents/fellows and faculty members.

III. DEFINITIONS / RESPONSIBILITIES

- A. The Graduate Medical Education Committee (GMEC) oversees resident/fellow and faculty member well-being through its Wellness Subcommittee.
- B. Monitoring of resident/fellow well-being
 - 1. Programs must monitor and address resident/fellow well-being, including making efforts to enhance the meaning that each resident finds in the experience of being a physician, attention to scheduling, work intensity, and work compression, evaluating workplace safety data, and addressing the safety of residents/fellows and faculty members.
 - 2. Situations that demand excessive service or that consistently produce undesirable stress on residents/fellows must be evaluated and modified.
 - 3. Programs must provide residents/fellows the opportunity to attend medical, mental health, and dental care appointments, including those scheduled during their working hours.
 - 4. The institution and programs will provide program faculty and residents/fellows with educational and self-screening materials concerning the identification of burnout,

Policy

Effective Date: 12/02/2019

Title: Well-Being Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

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depression, and substance abuse, including means to assist those who experience these conditions. This responsibility includes educating residents/fellows and faculty members in how to recognize these symptoms in themselves, and how to seek appropriate care. Additionally, this includes encouraging residents/fellows and faculty members to alert their program director, DIO, or other designated personnel or programs when they are concerned that another resident/fellow or faculty member may be displaying signs of burnout, depression, substance abuse, suicidal ideation, or potential for violence.

B. Counseling Services

1. The Medical Center's employee assistance program, Work & Life Matters (see www.cedars-sinai.org/programs/work-life-matters.html), provides a full range of confidential counseling and referral services to residents/fellows enrolled in training programs sponsored by CSMC. These include services provided by Bright Horizons (see <https://clients.brighthorizons.com/cedarssinai>) and services provided for all CSMC affiliated physicians through Life Matters by Empathia (call toll free 855-695-2816).
2. The services have been tailored to meet the needs of residents/fellows, and include services relating to dealing with impairment due to drugs or alcohol, or with any emotional difficulty irrespective of the nature or degree of seriousness of the problem as well as additional services, including for family members.
3. Information on Work & Life Matters and related services, including contact information and descriptions of services, is provided at orientation and is available to residents/fellows through the CSMC intranet page.
4. Utilization of counseling and related services is generally voluntary and at the discretion of the resident/fellow. However, an individual's participation may be required under certain circumstances.
5. The services of Work & Life Matters are confidential; however, the resident/fellow may request to sign a release that would allow Work & Life Matters to provide information to the program director or designee about attendance and compliance with recommendations.
6. Program directors shall ensure that program faculty and residents/fellows are aware of counseling and psychological support services available to them, and are sensitive to the need for timely referral to these services.

C. Well-being resources on Box

1. The GME Office curates well-being resource information and makes it available to all housestaff and others by request through a file sharing application that is accessible on all devices.

Policy

Effective Date: 12/02/2019

Title: Well-Being Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

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2. Categories of resources that are available on Box include:
 - i. Feeling down or anxious (includes crisis numbers and contact information for urgent counseling, self-screening resources, and links to wellness resources)
 - ii. Financial Wellbeing (includes budgeting, finance and legal resources, information about interest free loans available through the GME Office, and information about reimbursement for fatigue mitigation transportation)
 - iii. Health and Fitness (includes on-campus fitness class calendar and GME Wellness brochures, and information on sleep deprivation and fatigue mitigation)
 - iv. Housestaff Benefits (includes the current CSMC benefits reference guide for housestaff)
 - v. Housestaff Discounts (includes food, gym, phone, and retail discounts)
 - vi. Housestaff Executive Committee (includes departmental HEC representatives and minutes of recent meetings)
 - vii. Housing and Childcare (includes information on Work and Life Matters, Bright Horizons, and Empathia Work and Life Services available to housestaff)
 - viii. Recreation in Los Angeles (includes information on CSMC's Recreation Connection services)

D. Peer Support Groups

1. Work & Life Matters provides facilitation for program-level housestaff peer support groups. Programs may contact Work & Life Matters for information on how to start a group.
2. The GMEC encourages individual programs in developing customized peer support groups that meet regularly throughout the year.

E. Employee Wellness Program

1. The Cedars-Sinai Employee Wellness Program focuses on the seven dimensions of well-being, including emotional, spiritual, environmental, intellectual, occupational, social, and physical wellbeing.
2. In addition to extensive resources available through its website, the Employee Wellness Program offers monthly wellness "Lunch and Learn" programs on wellness topics of broad interest to which all housestaff are invited.

F. Wellness programs

1. The medical center provides an annual day-long physician well being program that is free to participants and for which continuing education credit is available.

Policy

Effective Date: 12/02/2019

Title: Well-Being Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

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2. GME offers periodic themed wellness programs that provide opportunities for housestaff in all programs to participate.

IV. PROCEDURES

- A. The GMEC, through the GME Office, will curate and provide access to resources and educational materials related to physician well-being.
- B. See Human Resources Policies "Performance Management: Fitness for Duty" and "Expectations: Drug-Free and Alcohol-Free Workplace" for procedures for handling non-adherence to the policies, including resident/fellow impairment. Continuation of patient care activities during evaluation or treatment of resident/fellow impairment is at the discretion of the program director.

IV. POLICY APPROVAL(S)

Graduate Medical Education Committee: November 12, 2019

Mark S. Noah, M.D.
Associate Dean for Medical Education
Designated Institutional Official

Original Effective Date: 09/01/06

Title: Grievance and Due Process Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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I. POLICY

It is the policy of Cedars-Sinai Medical Center to ensure that Physicians-in-Training are provided with fair policies and procedures for grievance and due process that minimize conflicts of interest and that support an educational environment for physicians-in-training in which they may raise and resolve issues without fear of intimidation, discrimination, or retaliation and in accordance with ACGME institutional requirements.

II. PURPOSE

The following procedures have been established and implemented for purposes of adjudication of Physician-in-Training complaints and grievances related to actions that could significantly threaten a Physician-in-Training's intended career development, including termination, non-renewal of the Physician-in-Training-Agreement (PITA), or non-promotion to the next level of training.

III. DEFINITIONS / RESPONSIBILITIES

A. Administrative Cause. The term "Administrative Cause" shall include, without limitation::

1. Failure of the Physician-in-Training to maintain such mandatory prerequisites as required by the Medical Center's teaching programs, including, without limitation:
 - (i) an active California medical license; (ii) current and complete D.E.A. Registration with all schedules except Schedule 1; and/or (iii) any other requisite certification(s).
2. Failure of the Physician-in-Training to comply with:
 - (i) requirements regarding the timely completion of medical records; (i) applicable Medical Center policies; and/or (iii) the Physician-in-Training Agreement with the Medical Center.

B. Medical Cause. "Medical Cause" as defined herein shall mean without limitation:

1. failure to comply with any of the terms of the Physician-in-Training's Agreement with the Medical Center or Medical Center Policies, other than that noted in Section III.A.1., above;
2. lack of academic achievement;
3. conviction of the Physician-in-Training of a crime involving moral turpitude;
4. unsuitable conduct or behavior; or
5. any aspect of the Physician-in-Training's lack of competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Title: Grievance and Due Process Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

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- C. Disciplinary Action. "Disciplinary action" as used herein shall mean:
1. any action by the Medical Center to terminate the Physician-in-Training's Agreement prior to the expiration of its full term or any restriction by the Medical Center upon the Physician-in-Training's full participation in Program activities, which is reportable to the: (a) Medical Board of California, pursuant to Section 805 of the California Business and Professions Code, as amended from time to time; or (b) National Practitioner Data Bank, pursuant to 45 C.F.R. Part 60, as amended from time to time; and
 2. such termination or restriction is based upon Medical Cause.

IV. PROCEDURES

- A. Initiation of Corrective Action. If the Department Chair or Program Director has received information indicating that there may be grounds for corrective action within the meaning of Article IX of the Physician-in-Training Agreement, he or she shall review such information to determine if the information, if true, would constitute Administrative Cause or Medical Cause for further corrective action. If the Department Chair or Program Director determines that such information, if true, would constitute Administrative Cause, he shall forward a report and recommendation to the Senior Vice President for Academic Affairs for review and action pursuant to Section IV.D.2. of this Policy. If the Department Chair or Program Director determines that such information, if true, may constitute Medical Cause, he or she shall proceed in accordance with the provisions of Section IV.B-D., below. Notwithstanding the preceding sentence, if the Department Chair or Program Director believes that the Medical Cause may constitute grounds for immediate summary suspension, he or she shall immediately contact the Senior Vice President for Academic Affairs for review and action, as appropriate.
- B. Further Investigation. If the Department Chair or the Program Director believe that the Physician-in-Training may have demonstrated Medical Cause for dismissal from the Program or for other action as described at Section III, above, the Program Director shall notify the Physician-in-Training of that belief. If the Department Chair or Program Director determines that further investigation is unnecessary following an interview with the Physician-in-Training, he or she shall proceed as provided in Section IV.C., below. If further investigation is deemed warranted, the Program Director shall appoint and convene a fact-finding committee composed solely of members in the Program Department. The Investigatory Committee shall conduct an investigation to ascertain the relevant facts. The Investigatory Committee may proceed in any manner appropriate to the nature of the investigation, including the taking of evidence outside of the presence of the Physician-in-Training. Such committee need not maintain a

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record of its proceedings. The Physician-in-Training shall have the opportunity to offer evidence and any other information pertinent to the proceedings of the Investigatory Committee. The Investigatory Committee shall present its recommendations and findings, jointly in writing, to the Department Chair and the Program Director. Copies of such recommendations and findings shall be given to the Physician-in-Training and to the Senior Vice President for Academic Affairs. The Investigatory Committee shall have no disciplinary authority.

- C. Recommendations. Upon a determination that further investigation is unnecessary, or upon receipt of an Investigatory Committee's recommendations and findings, the Department Chair and Program Director shall determine whether they believe the Physician-in-Training has demonstrated Medical Cause for dismissal from the Program or for other action, including, but not limited to conditions of probation and individual monitoring requirements. If the belief is that there is no basis for dismissal or other action, the Program Director shall promptly notify the Physician-in-Training, in writing, with a copy provided to the Department Chair and the Senior Vice President for Academic Affairs. If the Department Chair and Program Director recommend dismissal or other action, such recommendation shall be made, in writing, to the Senior Vice President for Academic Affairs.
- D. Review and Action By The Senior Vice President For Academic Affairs.
1. Medical Cause. If the Senior Vice President for Academic Affairs determines, based upon: (i) a review of the recommendation of the Department Chair and Program Director; and/or (ii) an independent evaluation of such other information as has been made available; that Medical Cause has been found for dismissal or for other Disciplinary Action, the Senior Vice President for Academic Affairs shall notify the Physician-in-Training, in writing, of the action intended to be taken ("Notice of Intended Action") and of the Physician-in-Training's right to a Fair Hearing as described at Section IV.F., below. The Senior Vice President for Academic Affairs may suspend the Physician-in-Training pending the outcome of the Fair Hearing. All stipend payments and benefits shall continue during any such suspension until expiration or earlier termination of the Physician-in-Training's Agreement with the Medical Center.
 2. Administrative Cause. If the Senior Vice President for Academic Affairs determines that Administrative Cause has been found in any case, the Senior Vice President for Academic Affairs shall notify the Physician-in-Training, in writing, of the action. In such circumstance, the Senior Vice President for

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Academic Affairs may take whatever action is required, including suspension or termination from the Medical Center's residency programs.

- E. Right to Request a Fair Hearing. If the Physician-in-Training is entitled to a hearing as provided in Section IV.F., below, or Article VII, Paragraph 7.5 of the Agreement regarding non-reappointment or non-renewal of the Agreement, or non-promotion to the next level of training, and desires to invoke the Fair Hearing procedure, the Physician-in-Training must notify the Senior Vice President for Academic Affairs of such intent, in writing, within thirty (30) calendar days after receipt of the Notice of Intended Action. If the Physician-in-Training does not request a Fair Hearing within the thirty (30) calendar day period after receipt of such notice, the action described in the notice shall be deemed accepted by the Physician-in-Training on the 31st calendar day following the Physician-in-Training's receipt thereof.
- F. Fair Hearing Rights.
1. Administrative Cause. In no event shall the Physician-in-Training be entitled to a Fair Hearing for any and all action taken as a result of Administrative Cause.
 2. Hearing Procedure.
 - (a) Whenever a Notice of Intended Action has been issued, and the Physician-in-Training has requested a Fair Hearing pursuant to the provisions of Section IV.E., above, the Senior Vice President for Academic Affairs shall convene a hearing of the House Staff Fair Hearing Committee (the "Committee"). The Committee is an ad-hoc committee of the Graduate Medical Education Committee of the Medical Center charged with conducting a fair hearing to determine the validity of both specific and general charges and to make written recommendations to the Senior Vice President for Academic Affairs regarding the intended Disciplinary Action.
 - (b) Such Notice of Intended Action shall set forth the basis for the action and advise the Physician-in-Training of the full scope of inquiry to be pursued, and the nature of charges made against him or her.
 - (c) The Senior Vice President for Academic Affairs shall appoint three (3) members from the Graduate Medical Education Committee to serve on the Committee. At least one member of the Committee shall be knowledgeable concerning the Physician-in-Training's specialty where

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feasible. The Committee shall be comprised of unbiased individuals who shall gain no direct financial benefit from the outcome, and who have not acted as an accuser, investigator, fact-finder, or initial decision-maker in the same matter. If it is not possible to appoint a Committee comprised entirely of members from the Graduate Medical Education Committee, members shall be appointed from the Medical Center's Medical Staff.

- (d) The Senior Vice President for Academic Affairs, in consultation with the Medical Center's Senior Vice President for Legal Affairs and General Counsel, shall appoint a presiding officer for the hearing from a panel of presiding officers developed by the Senior Vice President for Legal Affairs and General Counsel. The Presiding Officer shall gain no direct financial benefit from the outcome of the hearing. The Presiding Officer shall act as an independent, nonvoting, Chair of the hearing. It is his or her function to ensure that the Committee proceeds in accordance with this Policy. The Presiding Officer shall act to ensure that all parties at the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence. The Presiding Officer shall not act as a prosecuting officer nor as an advocate for either party to the hearing. The Presiding Officer shall determine the procedure to be followed during the hearing consistent with this Policy. The Presiding Officer shall have full authority and discretion to make all rulings on questions which pertain to procedure and the admissibility of evidence. The Presiding Officer shall be a nonvoting participant in the Committee's deliberations and shall prepare a written decision for the Committee's review and approval.
- (e) The Physician-in-Training shall receive written notice at least thirty (30) calendar days prior to the Committee hearing date. The written notice shall inform the Physician-in-Training of the date, time and location of the scheduled Committee hearing.
- (f) The Physician-in-Training shall have the right to a reasonable opportunity to voir dire the Committee members and the Presiding Officer, and the right to challenge the impartiality of any Committee member or the Presiding Officer. Challenges to the impartiality of any Committee member or the Presiding Officer shall be ruled on the Presiding Officer.

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Home Department: Academic Affairs/Graduate Medical Education

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- (g) Although formal rules of evidence are not followed by the Committee, the Physician-in-Training may be represented at the hearing by counsel or other third party if the Physician-in-Training so indicates, in writing, at least thirty (30) calendar days in advance of the hearing. If the Physician-in-Training elects not to be represented by counsel at the hearing, then the Program may not be represented by counsel at the hearing.
- (h) Prior to the Committee hearing, the Physician-in-Training shall have access to portions of his or her personal record of evaluation and medical records, insofar as they are relevant to the charges in the Notice of Intended Action . In addition, the Physician-in-Training shall be provided with all of the information made available to the Committee. In this regard, the Physician-in-Training shall have the right to inspect and copy, at the Physician-in-Training's expense, any documentary information relevant to the charges which the Program has in its possession or under its control, as soon as practicable after the receipt of the Physician-in-Training's request for a hearing. The Program shall have the right to inspect and copy, at the Program's expense, any documentary information relevant to the charges which the Physician-in-Training has in his or her possession or control as soon as practicable after receipt of the Program 's request.
- (i) The failure by either the Physician-in-Training or the Program to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to an individually identifiable Physician-in-Training, other than the Physician-in-Training under review. The Presiding Officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires. If a patient's medical records are pertinent to the proceeding, the Physician-in-Training must agree, in writing, not to further disclose any such medical records provided without the prior written authorization of the patient.
- (j) When ruling upon requests for access to information and determining the relevancy thereof, the Presiding Officer shall, among other factors, consider the following: (i) Whether the information sought may be introduced to support or defend the charges; (ii) the exculpatory or inculpatory nature of the information sought, if any; (iii) the burden

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imposed on the party in possession of the information sought, if access is granted; and (iv) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

- (k) Both parties to the hearing shall have the right to produce evidence, call witnesses and informally cross-examine other witnesses.
- (l) At the request of either side, the parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance. Continuances shall also be granted by the Presiding Officer upon agreement of the parties or upon a showing of good cause.
- (m) The Committee shall have a record made of the proceedings, copies of which may be obtained by the Physician-in-Training upon payment of any reasonable charges associated with the preparation thereof.
- (n) The burden of presenting evidence and proof during the hearing shall be as follows: (i) The Program shall have the duty to present evidence which supports the charge or recommended action; and (ii) the Program shall bear the burden of proving by a preponderance of the evidence that the action or recommendation is reasonable and warranted.
- (o) The Program and the Physician-in-Training shall each have the right to submit written statements at the close of the hearing.
- (p) The Committee shall submit a Written Report of a majority of the Committee to the Senior Vice President for Academic Affairs within fifteen (15) calendar days after the hearing. The Committee's report shall contain: (i) The facts found by the Committee to be true; (ii) the conclusions drawn by the Committee from such facts; and (iii) the recommendations of the Committee. The Committee's recommendations shall be limited to recommendations as to whether all or any of the possible Disciplinary Actions (including, where applicable, dismissal from the Program) or non-renewal of the Agreement or non-promotion to the next level of training presented by the Program at the hearing should be adopted as final. The Written Report shall be sent to

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Home Department: Academic Affairs/Graduate Medical Education

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Physician-in-Training, the Department Chair and the Program Director with a copy to the Senior Vice President for Academic Affairs.

- (q) Either the Program Director or the Physician-in-Training may appeal the recommendation of the Committee to the Medical Center's President and Chief Executive Officer by submitting a written request to that effect to the President and Chief Executive Officer. Any such request must be received by the office of the President and Chief Executive Officer within fifteen (15) days of the requesting party's receipt of the Written Report. In such event the record of the hearing before the Committee shall be prepared and forwarded to the President and Chief Executive Officer. In the event that neither the Program nor the Physician-in-Training submits a timely request for an appeal, the recommendations of the Committee shall become final.
- (r) Within fifteen (15) days of receipt of an appeal request, the President and Chief Executive Officer shall schedule and give notice to the parties of the time, date and place of a meeting with the President and Chief Executive Officer to consider the appeal. The notice of the meeting shall establish a schedule for submission of written statements from the parties in support of their positions with respect to the appeal. At such meeting each party shall be given a reasonable opportunity to orally state its position. For these purposes, the parties may be accompanied by an attorney or other representative. The President and Chief Executive Officer may request that the Medical Center's Senior Vice President for Legal Affairs and General Counsel, or his or her delegate, be present to advise him or her in the matter.
- (s) The appeal shall be based on the record of the hearing before the Committee, the Written Report of the Committee, and the written and oral arguments of the parties. The President and Chief Executive Officer will not consider any additional information unless he or she is satisfied that such information is relevant to the charges against the Physician-in-Training and that such information was improperly excluded or unavailable at the time of the hearing before the Committee. The President and Chief Executive Officer shall have a record made of the meeting. Within ten (10) days of the conclusion of the meeting to the hear the appeal, the President and Chief Executive Officer shall notify the Physician-in-Training, Senior Vice President for Academic Affairs, the Department Chair and the Program Director, in writing, of his or her

Policy



Effective Date: 08/08/2018

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decision which shall be the final decision in the matter at the Medical Center.

- G. Disciplinary Action in the Form of Suspension:
 - 1. During suspension, malpractice coverage maybe withdrawn.
 - 2. Suspended individuals may not treat patients.
- H. The procedure for suspension due to uncompleted medical records is detailed in Health Information Department policy entitled "Physician-in-Training Termination Process for Incomplete Records."

V. POLICY APPROVAL(S)

Graduate Medical Education Committee: August 7, 2018
Mark S. Noah, M.D.
Designated Institutional Official
Associate Dean for Medical Education

Original Effective Date: 03/01/09

Title: Physician-In-Training Complaints and Concerns Policy: Graduate Medical Education

Home Department: Academic Affairs/Graduate Medical Education

IMPORTANT NOTICE:

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I. POLICY

The Physician-in-Training is encouraged to seek resolution of complaints and other concerns relating to his/her appointment, responsibilities or other aspects of the educational experience.

- A. The Medical Center is committed to providing physicians-in-training with an educational environment in which they may raise and resolve issues without fear of intimidation or retaliation, and which minimizes conflicts of interest. In support of this, it is the Medical Center's policy to:
 1. Provide and support a Housestaff Association and Housestaff Executive Committee (see GME Policy "Housestaff Association and Housestaff Executive Committee").
 2. Provide and support a process for the adjudication of resident complaints and grievances related to the work environment or issues related to the program or faculty (see Section D, below).
 3. Establish and implement fair policies and procedures for grievance and due process of academic or other disciplinary actions taken against residents that could result in dismissal, non-renewal of a resident's agreement, non-promotion to the next level of training, or other actions that could significantly threaten a resident's intended career development (See GME Policy "Grievance and Due Process").
- B. This policy is applicable to all Cedars-Sinai residents whether they be on-campus or on rotation through a participating institution when the cause of the concern or complaint occurs. It is also applicable to all residents based at other institutions while on rotation through Cedars-Sinai.
- C. For matters of general concern, the Housestaff Executive Committee (HEC) provides a forum for discussion and acts as the liaison with the GME Committee and the GME Office, which may also be contacted directly. See GME Policy "Housestaff Association and Housestaff Executive Committee" for additional information.
- D. For matters of personal concern:

All discussions of personal concerns and complaints are to be kept confidential.

The Physician-in-Training is urged to first discuss complaints and similar concerns with the Program Director. Issues can best be resolved at this stage and every effort should be made to achieve a mutually agreeable solution.

If the complaint or concern is not adequately addressed to the satisfaction of the Physician-in-Training after thorough discussion with the Program Director, the Physician-in-

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Training may present the complaint or concern to the Department Chair for the purposes of achieving a mutually agreeable solution.

- E. In situations in which the complaint or concern is related to the Program Director and the Physician-in-Training believes that a fair resolution cannot be attained by presenting the complaint or concern to the Program Director, the Physician-in-Training may present the complaint or concern directly to the Department Chair.
- F. If the complaint is still not resolved to the satisfaction of the Physician-in-Training, or in situations where the complaint or concern relates to both the Program Director and the Department Chair, and the Physician-in-Training believes that a fair resolution cannot be attained by presenting the complaint or concern to those individuals, the Physician-in-Training may present the complaint or concern, in writing, directly to the Associate Dean, Medical Education/Designated Institutional Official.
- G. A physician-in training enrolled in an ACGME-accredited program may report training-related issues or allegations of non-compliance with ACGME requirements directly to the ACGME through its Office of the Ombudsperson or its Office of Complaints at www.acgme.org/Residents-and-Fellows/Report-an-issue.

II. PURPOSE

To provide for physicians-in-training a process in which concerns may be raised in a confidential and protected manner, and an environment in which they may raise and resolve issues without fear of intimidation or retaliation, and which minimizes conflicts of interest.

III. POLICY APPROVAL(S)

Graduate Medical Education Committee: January 7, 2020

Mark S. Noah, M.D.
Designated Institutional Official
Associate Dean for Medical Education

Original Effective Date: 03/01/09