

**CALIFORNIA CABG OUTCOMES REPORTING PROGRAM
Hospital Certification Form**

**Healthcare Information Division
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Sacramento, California 95811
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OSH-CCORP 416 (Revised 10/07)

Hospital Name: _____ OSHPD Identification Number:

Report period: From: To:
(Month) (Day) (Year) (Month) (Day) (Year)

Total Records in Submission: _____

Data collection tool used (check one): CCORP STS/Vendor Name: _____ In-house

Number of signed and completed CCORP Surgeon Certification Forms included with report: _____

INSTRUCTIONS for Statement of Certification: In the spaces provided, list the name(s) and California physician license number(s) of each surgeon who **did not complete and sign** a CCORP Surgeon Certification Form with this submission. If the CCORP Surgeon Certification Forms for all responsible surgeons are included with this submission, **write 'None'** across the Name/License area below.

Statement of Certification

I, _____, certify under penalty of perjury as follows:
(Name of CEO or Designee)

That I am an official of _____ and am duly authorized to submit this California
(Name of Hospital)

CABG Outcomes Reporting Program report, and that, to the extent of my knowledge and information, the accompanying data are true and correct, and that the definitions of data elements as set forth in Section 97174 of Title 22 of the California Code of Regulations have been followed by this hospital.

I certify that the following surgeon(s), if any, did not complete a CCORP Surgeon Certification Form and that each was provided the data for the cases assigned to him or her in this California CABG Outcomes Reporting Program report and was given an opportunity to review the data for accuracy and completeness.

<i>Surgeon First Name</i>	<i>Surgeon Last Name</i>	<i>CA physician license no.</i>	<i>Number of cases reported</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I also certify that each surgeon(s) listed above was informed that the data for his or her cases, after any corrections or revisions required by the Office of Statewide Health Planning and Development, will be used to compute his or her risk-adjusted mortality rate for coronary artery bypass graft surgery, and that the Office of Statewide Health Planning and Development will assign data elements with invalid or missing values the lowest risk value as observed in the most current risk-adjustment model for predicting mortality.

Name (CEO or Designee only): _____

Signature: _____

Date: _____

Telephone: _____ Email: _____

Address: _____