

CALIFORNIA CABG OUTCOMES REPORTING PROGRAM
Surgeon Certification Form

OSH-CCORP 415 (Revised 03/2/20)

Surgeon's name: _____
(First) (Middle Initial) (Last)

California Physician License Number: _____

Hospital name: _____

Facility Identification Number: _____

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

Number of records included in this report: _____

Statement of Certification

I have reviewed the data for the cases assigned to me in the final hospital report accepted on _____ (date) at _____ (time). I affirm that the cases were correctly assigned to me and attest to the accuracy and completion of the data. I understand that these data, after any corrections or revisions required by the Office of Statewide Health Planning and Development, will be used to compute my risk-adjusted mortality rate for coronary artery bypass graft surgery. I understand that for data elements with invalid or missing values OSHPD will assign the lowest risk value as observed in the most current risk-adjustment model for predicting mortality.

Signature: _____

Isolated CABG cases: _____	CABG + Valve cases _____	Other Non-isolated cases: _____
¹ Isolated CABG in-hospital deaths: _____	² CABG + Valve in-hospital deaths: _____	Other Non-isolated in-hospital deaths _____

1: Used in hospital and surgeon public reporting 2: Used in hospital public reporting

Hospital: Complete the section below only if the surgeon did not sign the form.

Surgeon unable to sign this form due to the following reason(s) (check any that apply):

- No longer performs surgery at this hospital
- Other (explain): _____

Fax Form to 916-445-7534
or
Email to CCORP@OSHPD.CA.GOV or
Upload in CORC