CALIFORNIA CABG OUTCOMES REPORTING PROGRAM

Surgeon Certification Form

OSH-CCORP 415 (Revised 06/17)

Surgeon's name: _____ _____ _____
(First) *(Middle Initial)l* *(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: _____

Number of Isolated cases: _____ Number of Non-isolated cases: _____

Number of Deaths: Isolated _____ Non-isolated _____

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):

☐ Unavailable at this time ☐ No longer works for this hospital

☐ Other *(explain):* _____

Fax Form to 916-445-7534