Short-Term, Elective Rotation, East Bay Surgery, New or Continuing
2017-2018 Visiting Housestaff Appointment Checklist and Cover Sheet
Office of Graduate Medical Education, UCSF

Please fill out this form completely and attach to the complete appointment packet for submission to the GME Office at least one month prior to rotation start date. Please place all paperwork in the order listed on this form. Do not include any paperwork in this packet that is not list below. Please submit all documents as single-sided documents with original signatures.

<table>
<thead>
<tr>
<th>Student Name</th>
<th>UCSF Department</th>
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<tbody>
<tr>
<td>Program/Rotations</td>
<td>Date Packet to GME</td>
</tr>
<tr>
<td>UCSF Program Coordinator</td>
<td>Training Supervisor</td>
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<tr>
<td>UCSF Coordinator Email</td>
<td>UCSF Coordinator Phone</td>
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<tr>
<th>document (required)</th>
<th>Attached</th>
<th>GME Approved</th>
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<tbody>
<tr>
<td>Application for Elective Rotation</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>Proof of Medical Malpractice Coverage</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
</tr>
<tr>
<td>Attestation (signed by trainee and UCSF Program Director)</td>
<td>□Yes □No</td>
<td>□Yes □No</td>
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Please explain any missing documentation.

GME Comments
Section 1 - To be completed by UCSF Program/Department:

Trainee Name ____________________________________________________________ Home Institution Name ________________________________

The above named Resident/Clinical Fellow (circle one) would like to apply for an Elective Rotation in the

UCSF Department of _____________________________ in the ACGME/Non-ACGME (circle one)

Training Program: _______________________________ (name of program) for the period

from __________ to __________ at (hospital) ______________ (location/ward) _______% ______

from __________ to __________ at (hospital) ______________ (location/ward) _______% ______

from __________ to __________ at (hospital) ______________ (location/ward) _______% ______.

UCSF Signatures:
Program Director/Division Chief/Chair: __________________________________________ Date: __________

UCSF Program coordinator/contact person: ________________________________________ Phone number: __________

Section 2 - To be completed by Resident/Clinical Fellow:

Previous Elective Rotation date(s) at UCSF, if any: ________________________________

Previous Department(s) for Elective Rotation(s): ________________________________

Current Health Insurance (list company name): __________________________________________

Date received HIPAA training and location (i.e. at home institution): ________________________________

Section 3 - To be completed by Trainee’s Home Institution:

Dr. ____________________________ is a ______ year (PGY___) Resident/Clinical Fellow (circle one) in
good standing in the Department of ______________________________. The trainee is authorized to
participate in the above listed elective rotation(s) at the University of California, San Francisco in the

ACGME/Non-ACGME (circle one) Training Program: _______________________________ (name of program).

Home Institution Signatures:
Program Director/Division Chief/Chair: __________________________________________ Date: __________

Name (print or type) ____________________________________________________________

Institution Name ________________________________

Address ________________________________

THE ABOVE NAMED RESIDENT/CLINICAL FELLOW IS CURRENTLY AND SHALL CONTINUE TO BE COVERED BY
MALPRACTICE INSURANCE PROVIDED BY HIS/HER HOME INSTITUTION WHILE PARTICIPATING IN CLINICAL TRAINING AT THE
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO. A SIGNED CERTIFICATE OF MALPRACTICE INSURANCE OR LIABILITY LETTER
IDENTIFYING THE INSURANCE CARRIER (OR SELF-INSURANCE PROGRAM) AND THE AMOUNT OF COVERAGE IS ATTACHED TO
THIS APPLICATION FORM. IF SUCH INSURANCE IS CANCELLED OR OTHERWISE FOUND TO BE INADEQUATE, IT SHALL RESULT IN
THE IMMEDIATE TERMINATION OR SUSPENSION OF THE ELECTIVE ROTATION.
Attestation (New Appointment) Office of Graduate Medical Education
University of California, San Francisco 2017-2018

Complete this form truthfully and in its entirety and sign below. The attached offer of a training position at UCSF is dependent upon the results of your signed attestation statement and its review by the program. Any “yes” response requires an explanation on a separate page. After review of your explanation of “yes” statements, our offer of a contract for training may be revoked or the conditions of the offer revised.

<table>
<thead>
<tr>
<th>Medical Education</th>
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<tr>
<td><strong>List each medical school you have attended.</strong></td>
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<tr>
<td>Name of School</td>
<td>City, State, Country</td>
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<tr>
<th>Examinations</th>
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<tr>
<td><strong>List all of the following exams you have taken: USMLE, COMLEX, FLEX, NBME, SPEX, QME, state boards.</strong></td>
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<td>Examination</td>
<td>Date (mm/dd/yyyy)</td>
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<tr>
<th>Postgraduate Training, Previous Employment, and Malpractice</th>
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<tbody>
<tr>
<td><strong>List all postgraduate training and employment since receiving medical degree. PLEASE ACCOUNT FOR ALL TIME SINCE GRADUATION (I.E. TIME STUDYING ABROAD).</strong></td>
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<td>Institution/Location</td>
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Any “yes” response to the questions below requires a detailed explanation on a separate page. Failure to provide an adequate explanation may result in the delay or rejection of your (re-)appointment.

1. Has any medical malpractice judgment been entered against you in any professional liability case(s)?
   - Yes
   - No

2. Has any settlement been made in any professional liability case in which you or your insurance carrier had to or agreed to make a monetary payment?
   - Yes
   - No

3. Are you aware of any malpractice claims currently pending/under investigation against you?
   - Yes
   - No

4. Has any policy been canceled, or has any professional liability insurer refused to renew your policy or placed limitations on the scope of your coverage?
   - Yes
   - No

5. Do you currently have, or have you had a problem associated with the use or misuse of drugs or controlled substances of any kind (whether obtained by prescription or otherwise), or alcohol? If yes, on a separate sheet please give a full explanation, including, without limitation, frequency and amount of use, the time period in which you engaged in such use, and the date last used.
   - Yes
   - No

6. Do you have any reason you cannot safely perform all the essential mental and physical functions related to the specific clinical privileges you are requesting or required by your agreement with your training program and the School of Medicine, with or without reasonable accommodation, according to accepted standards of professional performance, and without posing a significant health and safety risk to others? If yes, on a separate sheet, please describe the essential function(s) and state the reason why you may not be able to safely perform it.
   - Yes
   - No

7. Voluntarily or involuntarily, have any of the following ever been, or are currently being, denied, revoked, suspended, relinquished, withdrawn, reduced, limited, placed on probation, not renewed, or currently pending/under investigation?
   - Medical/Psychology license in any state
   - Yes
   - No
   - Other professional registration/license
   - Yes
   - No
   - DEA Certificate of registration
   - Yes
   - No
   - Academic appointment
   - Yes
   - No
   - Membership on any hospital medical staff
   - Yes
   - No
   - Clinical privileges, prerogatives/rights on any medical staff
   - Yes
   - No
   - Board Certification
   - Yes
   - No
   - Any other type of professional sanction
   - Yes
   - No

8. Have you been subject to any disciplinary action in medical school or a post-graduate training program, or in any health care organization or medical society, or is any such action pending?
   - Yes
   - No

9. Has any monitoring requirement been imposed?
   - Yes
   - No

10. Have you resigned or taken a leave of absence in order to avoid possible revocation, suspension, or reduction of privileges at any hospital, institution, or training program?
    - Yes
    - No

11. Have there been any, or are there any, misdemeanor or felony criminal convictions against you, or charges pending against you, including those under the Criminal Control Act?
    - Yes
    - No

12. Are there any pending or completed administrative agency, government, or court cases, decisions or judgments involving allegations that you failed to comply with laws, statutes, regulations, or other legal requirements that may be applicable to the practice of your profession or to your rendition of service to patients?
    - Yes
    - No

13. Are there any prior or pending government agency or third party payer proceedings or litigation challenging or sanctioning your patient admission, treatment, discharge, charging, collection, or utilization practices, including, but not limited to, Medicare Medicaid fraud and abuse proceedings or convictions?
    - Yes
    - No

Candidate for House Staff (Re-)Appointment
My signature below indicates that I have provided complete and truthful information and answered the questions on this page completely and honestly. I give permission for UCSF to validate any of the information provided above and in my CV, including, but not limited to, previous training, previous medical staff appointments, and medical degree, at any time.

______________________________
Candidate Signature

______________________________
Date

Program Director
My signature below indicates that I have reviewed this candidate’s responses to the questions and recommend him/her for housestaff (re-)appointment.

______________________________
Program Director Signature

______________________________
Date