Short-Term, Elective Rotation, Continuing, Licensed

2018-2019 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 listed below. Please submit all documents as single-sided documents with original signatures.

Student Name		UCSF Department	
Program/Rotations		Date Packet to GME	
UCSF Program Coordinator		Training Supervisor	
UCSF Coordinator Email		UCSF Coordinator Phone	

Document (required)	Attached	GME Approved
Application for Elective Rotation	□ Yes □ No	□ Yes □ No
Proof of Medical Malpractice Coverage	□ Yes □ No	□ Yes □ No
Attestation (signed by trainee and UCSF Program Director)	□ Yes □ No	□ Yes □ No
California license (print out from Medical Board website)	□ Yes □ No	□ Yes □ No
Health Statement (PPD)	□ Yes □ No	□ Yes □ No
Abuse Reporting Form	□ Yes □ No	□ Yes □ No
HIPAA Confidentiality Statement	□ Yes □ No	□ Yes □ No

Document (if applicable)	Attached	GME Approved
Visa (copy of DS-2019)	□ Yes □ No	□ Yes □ No

Please explain any missing documentation.

GME Comments

APPLICATION FOR ELECTIVE ROTATION FOR RESIDENTS & CLINICAL FELLOWS SCHOOL OF MEDICINE, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

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 INADEQAUTE, IT SHALL RESULT IN THE IMMEDIATE TERMINATION OR SUSPENSION OF THE ELECTIVE ROTATION.

CONTINUING RESIDENTS/CLINICAL FELLOWS - DATA FORM
UCSF, OFFICE OF GRADUATE MEDICAL EDUCATION

UCSF ID Assignment

SSN (REQUIRED): _____

NPI Number (**REQUIRED):** _____

First Name: _____ M. I. _____ Last Name: _____ Suffix: _____

Date of Birth: _____ / _____ / _____ UCSF ID NUMBER (will be assigned by system): _____

Name (Last, First Middle) _____ **Social Security Number** _____

Attestation (New Appointment) Office of Graduate Medical Education University of California, San Francisco 2018-2019

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.

Medical Education

List each medical school you have attended.

Name of School	City, State, Country	Date of Attendance (mm/dd/yyyy – mm/dd/yyyy)	Degree

Examinations

List all of the following exams you have taken: USMLE, COMLEX, FLEX, NBME, SPEX, QME, state boards.

Examination	Date (mm/dd/yyyy)	Pass/Fail

Postgraduate Training, Previous Employment, and Malpractice

List all postgraduate training and employment since receiving medical degree.
PLEASE ACCOUNT FOR ALL TIME SINCE GRADUATION (I.E. TIME STUDYING ABROAD).

Institution/Location	City, State, Country	Specialty/Activity	PGY Level	Dates (mm/dd/yyyy – mm/dd/yyyy)

Name (Last, First Middle) _____ **Social Security Number** _____

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

UCSF Medical Center

ADULT/CHILD ABUSE AND DOMESTIC VIOLENCE REPORTING REQUIREMENTS

California law requires that medical practitioners, non-medical practitioners, health practitioners and child care custodians working in specified public or private facilities be informed of their duty to report suspected child abuse, suspected dependent adult abuse, and suspected domestic violence. Please read the following carefully and sign where indicated:

Section 11166 of the Penal Code requires any child care custodian, medical practitioner, non-medical care practitioner or employee of a child protective agency who has knowledge of or observes a child his or her professional capacity or within the scope of his or her employment whom he or she suspects has been the victim of a child abuse to report the known or suspected instance of child to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving information concerning the incident.

Any person who fails to report an instance of child abuse which he or she knows to exists or reasonably should know to exist, as required, is guilty of misdemeanor and is punishable by confinement in the county jail for a term not to exceed six months or by a fine of not more than one thousand dollars ($1,000) or by both.

The law also provides that a person who does not report as required, or who provides a child protective agency with access to a victim, shall not be civilly or criminally liable for doing so.

Section 15630 of the Welfare and Institutions Code requires any care custodian, health practitioner, or employee of a health facility who is in his or her professional capacity, or within the scope of his or her employment of a health facility who is in his or her professional capacity, or within the scope of his or her employment, has knowledge of or observes a dependent adult who he or she knows has been the victim of physical abuse, or who has injuries is under circumstances which are consistent with abuse, to report the known or suspected instance of physical abuse to an adult protective services, agency or a local law enforcement agency immediately, or as soon as practically possible, by telephone, and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident. Reporting is required where the dependent adult's statements indicate, or in the case of a person with developmental disabilities, where his or her statements or other corroborating evidence indicates that abuse has occurred.

Sections 11160-11163 of the California Penal Code require that any health practitioner employed in a health facility, clinic or physician's office who, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a patient whom he or she knows or reasonably suspects has suffered from any wound or injury inflicted as a result of domestic violence or spousal abuse shall immediately, or as soon as is reasonably possible, file a telephone report to the local law enforcement agency followed by a written report within two working days.

Failure to comply with these reporting requirements may lead to a fine up to $1,000 and/or six months in jail.

A health practitioner who makes a report in accordance with this article shall not incur civil or criminal liability as a result of any report required or authorized by this article.

I certify that I have read and understand this statement and will comply with my obligations under the dependent adult abuse, child abuse, and domestic violence reporting laws.

Name (Please Print)	Position
Signature	Date

UNIVERSITY OF CALIFORNIA SAN FRANCISCO SCHOOL OF MEDICINE, GRADUATE MEDICAL EDUCATION

2018 – 2019 Health Statement for CONTINUING Residents and Clinical Fellows

Screening for tuberculosis is required. Both positive and negative TB skin test readings must be recorded in millimeters.

First Name _____ Middle Name _____ Last Name _____

Social Security Number _____ Department _____ Date of Birth _____ Gender _____

BACKGROUND INFORMATION

1) Have you traveled overseas in the past year? ☐ Yes ☐ No
If yes, where? _____

2) Country of birth _____

3) Have you worked in a prison or homeless shelter in the past year? ☐ Yes ☐ No

4) Have you entered a TB isolation room or had exposure to a known case of TB in the past year? ☐ Yes ☐ No

5) Have you been notified that your immune system is suppressed or compromised? ☐ Yes ☐ No

Note: HIV infection and other medical conditions may cause a TB skin test to be negative even when TB infection is present.

Have you ever received BCG vaccine? ☐ Yes ☐ No ☐ Don't Know
Year of most recent BCG _____ Country _____

Have you ever had any of the following symptoms for more than three weeks at a time?
(Please check **ALL** appropriate boxes)

Excessive sweating at night	☐ Yes	☐ No	Coughing up blood	☐ Yes	☐ No
Excessive weight loss	☐ Yes	☐ No	Hoarseness	☐ Yes	☐ No
Persistent coughing	☐ Yes	☐ No	Persistent fever	☐ Yes	☐ No
Excessive fatigue	☐ Yes	☐ No			

Note: If you have checked any symptoms, schedule an appointment with Occupational Health Services: (415) 885-7580

THOSE WITH A NEGATIVE TB SKIN TEST HISTORY

If you are TB skin test negative, please have a TB skin test placed and read within 3 months of start. **Please use only this form**. Skin tests may be obtained from Occupational Health Services. Contact Program Coordinator for TB clinic dates and times.

TB SKIN TEST APPLIED	Date applied mo/day/year	Site (RA/LA)	Lot#	Expiration Date mo/day/year	**TB SKIN TEST READ**	Date read mo/day/year	mm induration
	___/___/___	_____	_____	___/___/___		___/___/___	_____
Provider's name printed		Phone number			Provider's name printed		Phone number

Note: If you have a positive result, you must submit documentation of a recent chest x-ray.

For those who are authorized by Occupational Health Services to use Designated Readers, please carefully read the following: The following are designated to verify a negative PPD reaction: Attending Physicians, Administrative Nurses, Clinical Nurse Specialists, Nursing Supervisors and Respiratory Therapy Supervisors. **Only PPDs that are 0mm can be read by a designated reader. Record the 0mm in the above area under mm induration. If any redness or swelling/ induration develops at the skin test site, the skin test reaction must be ready by the Employee Health Services at your site. Reading must occur 48-72 hours after placement.**

THOSE WITH A POSITIVE TB SKIN TEST HISTORY (10mm or more)

Date of TB skin test conversion: _____ **mm Reading:** _____

Note: If you have become PPD positive within the past 12 months, you must submit documentation of a chest x-ray taken at the time of conversion.

INH / Other Therapy

INH Therapy Taken**:** ☐ **Yes** ☐ **No** **Other Therapy Taken**: ☐ Yes ☐ No

Length of Treatment: _____ mos. Length of Treatment: _____ mos.

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO CONFIDENTIALITY OF PATIENT, EMPLOYEE AND UNIVERSITY BUSINESS INFORMATION AGREEMENT

STATEMENT OF PRIVACY LAWS AND UNIVERSITY POLICY

It is the legal and ethical responsibility of all UCSF faculty, staff, house staff, students, trainees, volunteers, and contractors to use, protect, and preserve personal and confidential patient, employee, student, and University business information, including medical information for clinical or research purposes (referred to here collectively as "Confidential Information"), in accordance with state and federal laws and University policy.

Laws controlling the privacy of, access to, and maintenance of Confidential Information include, but are not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), the HIPAA Final Omnibus Rule, the California Information Practices Act (IPA), the California Confidentiality of Medical Information Act (CMIA), and the Lanterman- Petris-Short Act (LPS), and the Family Educational Rights and Privacy Act of 1974 (FERPA). These and other laws apply whether the information is held in electronic or any other format, and whether the information is used or disclosed orally, in writing, or electronically.

University policies that control the way Confidential Information may be used include, but are not limited to, the following: UCSF Medical Center Policies 05.01.04 and 05.02.01, LPPI Policies, UCSF Policy 650- 16 Minimum Security Standards, UCSF Policy 130-00 Disclosure of Information from Student Records, UC Standards of Ethical Conduct--University Resources, UC Personnel Policies PPSM 80 and APM 160, applicable union agreement provisions, and UC Business, UC Business and Finance Bulletin IS-3 Electronic Information Security, and Finance Bulletin RMP 8.

"Confidential Information" includes information that identifies or describes an individual, the unauthorized use, access or disclosure of which (a) is prohibited by federal or state laws, or (b) would otherwise constitute an unreasonable invasion of personal privacy. Examples of confidential employee and University business information include home address, telephone number, medical information, date of birth, citizenship, social security number, spouse/partner/relative names, income tax withholding data, performance evaluations, proprietary/trade secret information, and peer review/risk management information and activities. Most information in student records is confidential.

"Medical Information" includes the following no matter where it is stored and no matter the format: medical and psychiatric records, photos, videotapes, diagnostic and therapeutic reports, x-rays, scans, laboratory and pathology samples, patient business records (such as bills for service or insurance information), visual observation of patients receiving medical care or accessing services, and verbal information provided by or about a patient. Medical Information, including Protected Health Information (PHI), is maintained to serve the patient, health care providers, health care research, and to conform to regulatory requirements.

Unauthorized use, disclosure, viewing of, or access to Confidential Information in violation of state and/or federal laws may result in personal fines, civil liability, licensure sanctions and/or criminal penalties, in addition to University disciplinary actions.

University Privacy Policy and Acknowledgement of Responsibility

I understand and acknowledge that:

- It is my legal and ethical responsibility as an authorized user to preserve and protect the privacy, confidentiality and security of all Confidential Information relating to UCSF, its patients, students, activities and affiliates, in accordance with applicable laws and University policy.
- I will access, use and disclose Confidential Information only in the performance of my University duties, when required or permitted by law, and disclose information only to persons who have the right to receive that information. When using or disclosing Confidential Information, I will use or disclose only the minimum information necessary.

- I will discuss Confidential Information for University-related purposes only. I will not knowingly discuss any Confidential Information within hearing distance of other persons who do not have the right to receive the information. I will protect Confidential Information which is disclosed to me in the course of my relationship with UCSF.
- Special legal protections apply to and require specific authorization for release of mental health records, drug abuse records, and any and all references to HIV testing, such as clinical tests, laboratory or others used to identify HIV, a component of HIV, or antibodies or antigens to HIV. I will obtain such authorization for release when appropriate.
- My access to all University electronic information systems is subject to monitoring and audits in accordance with University policy.
- My User ID(s) constitutes my signature and I will be responsible for all entries made under my User ID(s). I agree to always log off of shared workstations.
- It is my responsibility to follow safe computing guidelines.
    - I will use **encrypted** computing devices (whether personal or UCSF-owned), such as desktop computers, laptop computers, tablets, mobile phones, flash drives, and external storage, **for any UCSF work purpose** which involves the use, exchange, or review of Protected Health Information or Personally Identifiable Information, including but not limited to, clinical care, quality reviews, research, educational presentations/conferences, and financial or personnel-related records. Encryption must be a UCSF-approved solution.
    - **I may be personally responsible** for any breach of confidentiality resulting from an unauthorized access to data on an unencrypted device due to theft, loss or any other compromise. I will contact the UCSF IT Service Desk at (415) 514-4100 for questions about encrypting my computing device.
    - I will not share my **Login or User ID and password** with any other person. If I believe someone else has used my Login or User ID and password, I will immediately report the use to the UCSF IT Service Desk at (415) 514-4100 and request a new password.
- Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to or use or disclosure of patients' Confidential Information may subject me to civil fines for which **I may be personally responsible**, as well as criminal sanctions. Under University policy, I may also be subject to disciplinary action up to and including immediate termination from my employment/professional relationship with UCSF.

By signing below:

- **I attest that I have encrypted or will encrypt all of my personal computing devices before using them for any UCSF work purpose, unless I have an encryption exception approved by the UCSF Information Security Officer. I will not use an unencrypted computing device for UCSF work purposes without an approved exception.**
- **I attest I have read, understand, and acknowledge all of the above STATEMENTS OF UNIVERSITY PRIVACY POLICY and the ACKNOWLEDGEMENT OF RESPONSIBILITY.**

_____	_____
Signature	Date
_____	_____
Print Name	UCSF Department
_____	_____
UCSF Employee Number	Signature of Manager or UCSF Representative
❑ Non-UCSF Employee	_____
	Print Manager or UCSF Representative Name