Short-Term, Elective Rotation, East Bay Surgery, New or Continuing

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

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.

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