
OVERVIEW FOR VISITING RESIDENT/FELLOW AT UNIVERSITY OF CINCINNATI MEDICAL CENTER

Required documents*: *Incomplete applications will not be accepted.*

- Copy of Ohio medical training certificate or permanent license (if military, anywhere in US)
- Copy of medical school diploma
- Copy of current CV
- Copy of malpractice insurance (not necessary if military or UC Health employee)
- If foreign, copy of ECFMG certificate
- Flu shot documentation (November through March)

Required Forms (attached)*:

- Application
- Authorization for Release of Health Information
- Confidentiality and Data Security Agreement
- EPIC

IMPORTANT: If a resident/fellow returns to University of Cincinnati Medical Center for an additional rotation within one (1) year of their last rotation here then **ONLY** a new application page is required. All of the forms on the left, other than the application page, are not required.

APPLICATIONS MUST BE RECEIVED THIRTY (30) DAYS PRIOR TO REQUESTED ROTATION DATE. Once the application is received someone from our office will confirm your application packet is complete. If you do not hear from us please follow up immediately.

Faxed applications are not accepted.

Again, if any of the following are missing, the application packet will not be accepted or processed.

Prior to starting your rotation, or on the first day of, you're required to visit the GME Office to sign in. At this time we will also ensure that you have all the peripherals (parking, ID badge, scrubs, etc.) you will need during your rotation.

Completed applications must be submitted to the UCMC Program Coordinator

Thank you.

Lynn Romer

Office of Graduate Medical Education

513-584-1705



External Rotator Checklist: Please use this checklist to ensure that ALL items have been attached and completed in full. The application must be returned to the department in which the rotation is to take place at least 5 weeks prior to the start of a rotation. The UCMC Office of Graduate Medical Education must receive this application interdepartmentally at least **4 WEEKS PRIOR TO THE START OF THE ROTATION**. If you have any questions regarding this process, please do not hesitate to contact us at (513) 584-1705.

Name: _____ Current Hospital: _____

Rotation Date: _____ Current Program: _____

Required Documents:

___ Copy of current Ohio State Medical Board Training Certificate or Permanent License (anywhere if military)

___ Copy of Medical School Diploma (including translation, if applicable)

___ Copy of valid ECFMG Certificate (if applicable)

___ Copy of current CV

___ Copy of Malpractice Insurance indicating minimum coverage amount (not necessary if military)

___ Copy of Influenza vaccination documentation and recent TB result (November-March rotations)

Required Forms:

___ Rotator Application COMPLETE and FULLY SIGNED by both home & away Program Directors

___ Authorization for Release of Health Information

___ Confidentiality and Security Agreement

___ Epic training

UCMC Program Coordinator: _____

VISITING ROTATOR APPLICATION: *This form must be completed and submitted to the office of Graduate Medical Education with the appropriate documentation attached and all signatures obtained no less than thirty (30) days prior to the rotation start date.*

Name: _____ **DOB:** _____
 (Last) (First, Middle Initial)
SS#: _____ **NPI:** _____ **Sex:** M F
Ohio License/Training Certificate#: _____ **Exp date:** _____
DEA# _____ **Degree:** _____ **Pager:** _____ **Cell:** _____
Email: _____ **PGY Level:** _____

Have you rotated here before?: Yes No If yes, what program? _____

Rotation Applying for: _____ **Dept:** _____

Rotation Dates: _____ to _____ **Supervising Physician (UH):** _____

Name of Parent Institution: _____

Coordinator Name: _____ **Coordinator phone & email:** _____

Current Program: _____ **Residency Start/End Date:** _____

Medical School: _____ **Graduation Date:** _____

International: Yes No If Yes, ECFMG #: _____ **Issue date:** _____

Previous GME Training? Yes No If yes, please list Name of Institution(s) and approximate date(s):

Institution/City&State: _____
PGY Level: _____ **Program:** _____ **Beg/End Dates:** _____ to _____

Institution/City&State: _____
PGY Level: _____ **Program:** _____ **Beg/End Dates:** _____ to _____

Institution/City&State: _____
PGY Level: _____ **Program:** _____ **Beg/End Dates:** _____ to _____

Institution/City&State: _____
PGY Level: _____ **Program:** _____ **Beg/End Dates:** _____ to _____

Certification and Signatures:

This certifies that the above trainee/applicant is in good academic standing in the aforementioned training program, and our Office/Program has verified his/her qualifying credentials in accordance with the Joint Commission standards as well as the following items: fully covered by health insurance, malpractice insurance provided by the parent institution (\$1M/\$1,000,000), current training certificate or license to practice medicine in Ohio, all immunizations up to date; Hepatitis B vaccine; Tetanus, Measles; mumps; Rubella(MMR) vaccine since 1980 or proof of immunity; Varicella immunization or documentation of immunity; influenza if applicable, TB skin test performed in the last year, completed training in Universal Precautions, Blood borne, and Airborne Pathogens within the past year, and received training with respect to the HIPAA standards for patient confidentiality and privacy.

 Current Program Director (please print)

 Signature of Current Program Director/Date

 UCMC Program Director

 Signature of UCMC Program Director/Date

 Signature of GME Director:

 Date:



Rotating Resident UC Health Compliance & Business Ethics Acknowledgement

I certify that I have taken Compliance, HIPAA Privacy and Information Security training at my primary healthcare employer within the last 3 years.

I have received the UC Health Code of Conduct and understand that it is my responsibility to read and comply with the legal and ethical practices contained in the Code of Conduct.

Should I witness any compliance issues or concerns, I must report it to a supervisor, to the Human Resources Department, the Compliance and Business Ethics Department (513-585-7224; Compliance@UCHealth.com) or the Compliance HelpLine (1-866-585-8030). I understand I can report issues or concerns anonymously through the Compliance Reporting form found on the homepage of the UC Health Intranet or through the Compliance HelpLine at 1-866- 585-8030.

I understand that UC Health has organization specific policies regarding Compliance, HIPAA Privacy and Information Security.

I understand that it is against UC Health policy to access any individual's medical record for which I do not have a legitimate business purpose to access. More specifically, I cannot view my own medical record, loved ones medical records, co-workers medical records, individuals who have been in the news or media medical records (to name a few examples) unless I am involved in the direct care and treatment, payment or healthcare operations of the individual on behalf of UC Health. If I need access to this information for personal reasons, I must access through MyChart.

I am aware that violations of the Code of Conduct and UC Health policies and procedures may result in disciplinary action that addresses my behavior.

I understand how to access UC Health's policies should I need to refer to them.

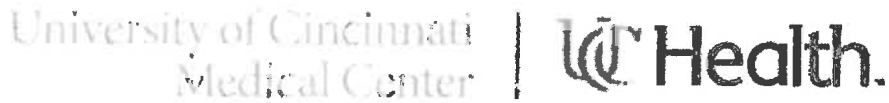
Printed Name: _____

Signed Name: _____

Date: _____

Department: _____

Primary Healthcare Employer: _____



Authorization for Release of Health Information

Name: _____

Maiden Name: _____

Address: _____

Telephone Number: _____

Birthdate: _____ Social Security Number: _____

I authorized the use of disclosure of the above named individual's health information described below:

Organization making disclosure: _____

Information may be disclosed to: _____

Address: _____

For the purpose of _____ dates of visits: _____

Place an (X) to indicate the information to be released:

- | | |
|----------------------------|----------------------------|
| Drug Screen Results _____ | Physician reports _____ |
| Immunization Records _____ | Therapy reports _____ |
| Chest X-ray report _____ | Consultation reports _____ |
| Titer results _____ | Other _____ |
| TB test results _____ | |

I understand that I have the right to revoke this authorization at any time by sending a written revocation to Alliance Employee Health 3200 Burnet Avenue Cincinnati, Ohio 45229. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on your date of termination.

I understand that authorizing the disclosure of this health information is voluntary and Employee Health will not condition the provision of treatment or payment to me on the signing of this authorization, except for the provision of research related treatment to me in the signing of this authorization for the use or disclosure of my personal health information for such research.

I understand that authorizing the disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

I understand that my health record may include information related to alcohol and/or drug dependence abuse, behavioral or mental health conditions, acquired immunodeficiency syndrome, or human immunodeficiency virus. This release is sufficient for release of drug/alcohol diagnosis and treatment and HIV test results or diagnosis.

Patient or Representative Date

Relationship to Patient Witness

CONFIDENTIALITY AND DATA SECURITY AGREEMENT

PLEASE READ THE ENTIRE AGREEMENT.

During the course of my daily job duties, I will have access to confidential UC Health information. The services provided by UC Health for its patients and other customers are highly confidential and must not be released, disclosed or discussed with anyone either inside or outside of the hospitals and practice offices. When accessing and utilizing this confidential information, I recognize that there are both Federal and State Laws which protect patient identifiable healthcare information (PHI), medical records and other confidential information from unauthorized access, use and disclosure. I also understand that by signing or electronically acknowledging/signing this agreement, there may be legal, ethical, and personal ramifications for violating its terms.

Confidential information includes, but is not limited to, information about a patient's condition, treatment or payment for services, aggregate clinical data, employee records, processes, marketing plans or techniques, product or service plans, strategies, forecasts, customer/patient lists, supplier lists, discoveries, ideas, pricing policies and financial information. This confidential information can be obtained through a variety of means including seeing or hearing it, access to computer systems or access to PHI in paper form or in the electronic medical record.

When accessing and using confidential information, I agree to abide by the following:

- I agree to keep confidential all information accessed.
- I agree to access only those specific elements of information for which I have been authorized by virtue of my password(s) and for which I have job responsibility reasons to access.
- I agree to keep my password confidential and not share it (them) with any individual or allow any individual to access information through my password(s). I understand that giving a password to an unauthorized individual may result in disciplinary action up to and including termination.
- I understand that my password(s) may identify information that I have accessed and that this access may be monitored.
- I understand that my password(s) will be changed periodically to help maintain the security of UC Health.
- I understand that I must protect data at all times. This includes data in electronic, paper, film, video or other forms. Data will be protected during its origin, entry, processing, distribution, storage and disposal.
- I understand that I must protect data from unauthorized access (accidental or intentional), modification, destruction or disclosure.
- I understand that data used in business and clinical operations is an asset of UC Health. I further understand that all UC Health employees must protect this data from unauthorized access.
- I understand that E-mail is the property of UC Health and its member institutions
- I understand that I should have no reasonable expectation of privacy when using UC Health E-mail or Internet and that usage of either may be monitored

- I understand that should I have access to the Internet, it is provided to UC Health employees to assist in completion of job assignments (i.e. patient care, research, education).
- I understand that access to the Internet should be considered an extension to my normal environment.
- I understand that UC Health may monitor usage or restrict access of the Internet.
- I understand that the use of unlicensed or unapproved software constitutes a serious risk to UC Health operations.
- I understand that upon my termination of employment, my ability to access UC Health information will end. I agree that I will not attempt to access the systems or disclose any confidential information to any person or entity at that time.
- I agree to access, use or disclose only PHI for which I am authorized through my work for UC Health and as complies with UC Health HIPAA policies. I agree not to invade patient privacy by examining PHI or data for inappropriate review.
- I understand that examination of my own records, family member records or others for non-work related purposes is not permitted and is a violation of UC Health policy.
- I agree not to discuss PHI in unauthorized areas such as hallways, elevators and cafeterias, where it could be overheard.
- I agree not to make unauthorized disclosures, copies or transmissions of PHI in any form including electronic transfer of PHI to personal devices.
- I understand that any access to PHI for research purposes requires proper documentation and approval according to HIPAA policies. I understand that UC Health may monitor and audit my access to PHI.
- I understand the use of interconnect functionality, e.g. Epic Care Everywhere, to retrieve PHI from non UC Health hospitals for the purposes of research is strictly forbidden. Interconnect functionality is limited to treatment, billing, or healthcare operations.
- I understand unauthorized access, use or disclosure of PHI may subject UC Health to Federal and State fines and penalties
- I understand that access to PHI for criminal purposes will subject me to prosecution to the full extent of the law.

I have read this document and understand that my signature constitutes my acceptance of the terms of this agreement and that a violation of this agreement can result in disciplinary action up to and including termination of my employment. I also recognize that by signing or electronically acknowledging this agreement, there may be serious legal, ethical and personal consequences for violating its terms.

Employee Name (Print)

Department/Hospital or Facility

Employee Signature

Date

Employee Number

EPIC

University Hospital is now using EPIC for ambulatory and inpatient settings.

Are you currently using EPIC? yes no

Will you see patients in our clinics during your rotation? yes no

If your rotation includes clinic shifts, you will need to attend a class for EPIC rotators which lasts for approximately 4 hours. New EPIC user training classes are held on Mondays from 8am-Noon.

If your rotation location will not include clinics and you are a current EPIC user you may test out. These sessions take approximately 30 minutes and will give you access only for inpatient functions.

The Graduate Medical Education office will schedule your test out session and the EPIC class for rotating physicians.

Please contact the Office of Graduate Medical Education at (513) 584-1705.

Name(Print): _____

Signature: _____

Phone number: _____

Date: _____