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
- Computerized medical record access request
- Addendum to application
- 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 and returned to the GME office 4 weeks prior to 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 in US if military)
_____ Copy of Medical School Diploma including Translation, if applicable (always needed, even military)
_____ Copy of Valid ECFMG Certificate if applicable (includes all foreign students)
_____ Copy of Current CV
_____ Copy of Malpractice Insurance indicating Minimum Coverage Amount (Not necessary if in UC Health or military)
_____ Copy of Influenza vaccination (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
_____ Access Anywhere/ Computerized Medical Record Request
_____ EPIC training

Contact:
_____ University of Cincinnati Medical Center Program Coordinator

For GME Office Use Only:
_____ Enter information into MedHub
_____ Request EIN
_____ Email resident to expect JOBS email
_____ Register for EPIC training and request EPIC access
_____ Welcome email to resident and copy coordinators

Flu Documentation: _______  (Oct – March)

EPIC ID: ________________  Password: ___________________  Vaccination Date: ________________
 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):

<table>
<thead>
<tr>
<th>Institution/City&amp;State</th>
<th>PGY Level</th>
<th>Program</th>
<th>Beg/End Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institution/City&amp;State</td>
<td>PGY Level</td>
<td>Program</td>
<td>Beg/End Dates</td>
</tr>
<tr>
<td>Institution/City&amp;State</td>
<td>PGY Level</td>
<td>Program</td>
<td>Beg/End Dates</td>
</tr>
<tr>
<td>Institution/City&amp;State</td>
<td>PGY Level</td>
<td>Program</td>
<td>Beg/End Dates</td>
</tr>
</tbody>
</table>

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: ____________________________
PROCEDURAL COMPETENCY ATTESTATION - CENTRAL LINES

Training programs at the University of Cincinnati Medical Center/College of Medicine have a visual and online certification system for residents and fellows deemed to be competent by a Program Director to insert/withdraw central lines without direct supervision. This competency, or need for direct supervision, must be identified for all visiting residents by the sponsoring institution Program Director prior to a rotation at the University of Cincinnati Medical Center/College of Medicine.

Does this resident meet the competency for the insertion AND removal of a Central Line WITHOUT DIRECT SUPERVISION?

______ Yes
______ No

If “Yes”, please describe the process you have used for this determination: ________

____________________________________________________________________
____________________________________________________________________

Resident Name: _________________________________________________________

Program Director Name: ________________________________________________

Program Director Signature: _____________________________________________

Program Director Phone Number: _________________________________________

Date: __________________________________________________________________
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
Contractors or Non-employees

PLEASE READ THE ENTIRE AGREEMENT.

As a contractor or non-employee of UC Health, you have a legal obligation to protect the rights of patients as defined under the Health Insurance Portability and Accountability Act (HIPAA). You are required to keep confidential Protected Health Information and other vital data you may access during the course of your work for or associated with UC Health. The following defines this information and provides a series of statements you must review to fully understand your obligations, as well as appropriate use of the Internet at UC Health.

Description of Protected Health Information (PHI)
PHI includes patient identifiable health information, medical records and financial or billing information relating to a patient’s past, present or future mental or physical condition; or past, present or future provision of healthcare; or past, present or future payment for provision of healthcare. It may be in oral, paper or electronic form and contains any of the following identifiers that may be used to identify the patient:

- Name
- Place of residency (including street address, county, city, zip code)
- Telephone/fax numbers
- E-mail addresses
- Social Security Number
- Medical Record Number
- Health plan beneficiary number
- Account numbers
- Birth date, admission date, discharge date, date of death, all ages over 89
- Certificate/license numbers
- Vehicle identifiers and serial numbers including license numbers
- Device identifiers/serial numbers
- Web Universal Resource Locators (URLs, i.e. web page identifiers), Internet Protocol (IP address number)
- Biometric identifiers (voice, finger prints)
- Full face photo image
- Any other unique identifying number, characteristic, or code

Description of Other Confidential Information
Confidential information also includes, but is not limited to, combined 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 hearing it, seeing it, viewing the paper or electronic medical record or accessing it in a hospital computer system.
Requirements of All UC Health Contractors or Non-Employees Regarding PHI and Confidential Information

The services provided by UC Health and corresponding PHI are highly confidential and must not be released or discussed with unauthorized persons. There are both Federal and State Laws which safeguard the privacy and confidentiality of PHI and other confidential information from unauthorized access, use or disclosure.

Contractor or Non-Employee Agreements Regarding Use of PHI, Confidential Information and the Internet

- I agree to abide by UC Health HIPAA policies on privacy and confidentiality of PHI.
- I agree to access, use or disclose only PHI for which I am authorized through my work for or associated with 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 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.
- If given a system password(s) to use, I agree to keep it (them) 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 contract or account access termination.
- I understand my password(s) may identify information that I have accessed, which may be monitored and audited.
- I understand my password(s) may be changed periodically to help maintain the security of UC Health.
- I understand that I must safeguard data at all times – during its origin, entry, processing, distribution, storage and disposal. This includes data in electronic, paper, film, video or other forms.
- I understand that I must safeguard 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 understand that e-mail is the property of UC Health and its member institutions and may be monitored. I further understand that I should have no reasonable expectation of privacy when using UC Health e-mail or Internet.
- I understand that, should I have access to the Internet, it is provided by UC Health to assist in completion of work assignments (i.e. patient care, research, education). I understand that this access should be considered an extension of my work environment.
- I understand that the use of unlicensed or unapproved software constitutes a serious risk to UC Health operations.
- I understand that upon my contract termination or end of work with UC Health, 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 and/or PHI to any person or entity at that time.

- I understand at the termination of my contract or end of work with UC Health, I will return any confidential information including PHI that is in my possession, to UC Health.
- I understand I must continue to honor all of the obligations mentioned above after termination of my contract or end of work with UC Health.
- I understand that UC Health reserves the right to immediately terminate my access to electronic medical records if there is inappropriate access to PHI.
- I understand that unauthorized access, use or disclosure may have serious legal repercussion for me and/or my employer.
- I understand unauthorized access, use or disclosure of PHI may subject me and/or UC Health to Federal and State fines and penalties.
- I understand that access to PHI for illegal 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 it can result in disciplinary action, up to and including termination of my contract or relationship with UC Health and/or termination of my access to UC Health electronic systems including the electronic medical record. I also recognize that by signing this agreement, there may be serious legal, ethical and personal consequences for violating its terms.

Name (Print) ____________________________ Organization (Print) ____________________________

Signature ____________________________ Date of Signature ____________________________

Date of Submission or Receipt ____________________________
ADDENDUM TO APPLICATION FORMS USED TO REQUEST ACCESS TO HIPAA DEFINED PHI FOR RESEARCH PURPOSES

PLEASE CHECK ONLY ONE BELOW and note that FEDERAL REGULATIONS PROHIBIT THE USE OF PHI FOR RESEARCH WITHOUT PROPER DOCUMENTATION

☐ I require access only for activities necessary to treat patients, to solicit or obtain payment for patient treatment or for hospital operations and I will not use my access for research purposes. Check for: ☐ treatment and/or ☐ payment and/or ☐ hospital operations

☐ I require access only for research purposes and I am providing appropriate documentation (listed below) which includes informed consents signed before April 14, 2003 for research projects already underway, and/or an IRB waiver, and/or signed patient authorizations. The starting date _______________ and ending date _______________ define the period that I need access for research purposes for this research project entitled _______________. I agree to produce appropriate documentation for research from now on should I be requested to by UC Health.

☐ I require access to treat and/or solicit payment for treatment services and I also require access for research purposes and I am providing appropriate documentation (listed below) which includes informed consents signed before April 14, 2003 for research projects already underway, and/or an IRB waiver, and/or signed patient authorizations. The starting date _______________ and ending date _______________ define the period that I need access for research purposes for this research project entitled _______________. I agree to produce appropriate documentation for research from now on should I be requested to by UC Health.

DOCUMENTS ATTACHED (PLEASE LIST BELOW)

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Above list authorizations, IRB waivers, patients (both with and without consents), any other IRB documents - BE SURE TO INCLUDE ANY LISTS OF PATIENTS

NAME OF PRINCIPAL OR CO-PRINCIPAL _________________________________________________________
INVESTIGATOR(S) – PLEASE PRINT ____________________________________________________________

Signatures(s) _____________________________________________________________________________
_________________________________________________________________________________________

Signatures attest that documentation will be maintained for any future audit purposes.
Computerized Medical Record
Access Request
HIPAA Re-application Form

Date: __________

*Name: __________________________________________
(First Name) (Middle Initial) (Last Name)

*Title: ____________________________________________
(include M.D., Ph.D., R.N., Medical Student, etc.)

*Your Signature: ________________________________

*Department/Service: ______________________________

Work Number: ____________________ Pager Number: ________________

E-Mail Address: _____________________________

*Department Director: _______________________
(University of Cincinnati Medical Center PROGRAM DIRECTOR)

Director Phone Number: _______________________
(University of Cincinnati Medical Center DEPARTMENT CONTACT NUMBER)

ACCESS INFORMATION

USER ID: ________________________________

PASSWORD: Medical Record Services will provide you with the password
(When receive access the required field-Minimum is 8 letters and/or numbers)

This is your unique access to the Medical Record Document Imaging System. Your user access is
CONFIDENTIAL. Do not share your access code with anyone. If you feel your access has been
compromised, please contact Medical Record Services immediately at 584.4655. If found violating
the Confidentiality Policy, your director will be notified and your access may be suspended.
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:______________________________