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):

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.

_________________________________________ 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: ________________________________

UC Health Code of Conduct: https://med.uc.edu/gme/externalrotators
Authorization for Release of Health Information

Name: ____________________________
Maiden Name: ____________________________
Address: ____________________________________________
Telephone Number: ____________________________
Birthdate: ____________________________ Social Security Number: ____________________________

I authorize 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
- Immunization Records
- Chest X-ray report
- Titer results
- TB test results
- Physician reports
- Therapy reports
- Consultation reports
- Other

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.

UC Health HIPAA Addendum to Applications Forms.doc

Last Revised: 11/01/2010
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.
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:____________________________________________