
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 Ohio Permanent Medical License (if military, anywhere in US)
- Copy of Medical School Diploma
- If foreign medical diploma, copy of ECFMG certificate
- Current CV
- Copy of Malpractice Insurance (not necessary if military)
- COVID19 Vaccination Documentation
- Flu Vaccination Documentation (November through March)

Required Forms (attached)*: *Incomplete applications will not be accepted.*

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

IMPORTANT: If a resident/fellow returns to University of Cincinnati Medical Center for multiple rotations, **ONLY** a new application page is required for each subsequent rotation. However, a **copy of malpractice insurance and flu vaccination documentation are required annually.**

APPLICATIONS MUST BE SUBMITTED BY UCMC TRAINING PROGRAM A MINIMUM OF THIRTY (30) DAYS PRIOR TO REQUESTED ROTATION DATE. The UCMC GME Office will contact you several weeks prior to the start of the rotation. If you do not hear from someone, please follow up immediately.

A complete application and required documentation must be submitted to the UCMC department in which you wish to rotate.

Thank you,

UCMC, 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 ROATION**. 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 Ohio Permanent Medical License

___ 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 COVID19 Vaccine Documentation

___ 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, via the department in which the rotation is requested, with the required documentation attached, and all signatures obtained, no less than thirty (30) days prior to the rotation start date.*

LAST NAME: _____ FIRST, MIDDLE INITIAL: _____

DATE OF BIRTH: _____ SSN: _____ NPI: _____

DEGREE: _____ CELL: _____ PAGER: _____ PGY LEVEL: _____

EMAIL: _____

HAVE YOU ROTATED HERE BEFORE? Yes _____ No _____ If yes, what program? _____

ROTATION APPLYING FOR: _____ DEPARTMENT: _____

ROTATION DATES: _____ TO _____ SUPERVISING PHYSICIAN (UCMC): _____

NAME OF HOME INSTITUTION: _____

CURRENT PROGRAM: _____ COORDINATOR NAME: _____

COORDINATOR PHONE & EMAIL: _____

MEDICAL SCHOOL: _____ GRAD DATE: _____

(If International, provide ECFMG # & Issue Date): _____

HAVE YOU TRAINED IN EPIC AS AN EMR? YES _____ NO _____

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 proved by the parent institution (\$1M/\$1,000,000) current training certificate or license to practice medicine in Ohio, all immunizations are 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 when applicable; TB skin test; COVID19. Trainee must have completed training in Universal Precautions, Bloodborne, 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): _____

Current Program Director Signature/Date: _____

UCMC Program Director (please print): _____

UCMC Program Director Signature/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

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