Resident/Fellow Application

Highlighted information required to process

Personal Information		
Name (Last)	**(First)**	**(Middle)**
Address		
City, State and Zip Code		
Social Security Number (indicate if issued in USA or Canada)	**Date of Birth**	
Home Phone Number	**Cell Phone Number**	**Pager Number**
E-Mail Address		
Undergraduate Education		
University Name		
City	**State/Country**	
Month/Day/Year of Graduation (must complete with full date)	**Degree**	
Medical Education	***School Code (to be completed by WJMC GME)***	
University Name		
Address	**City**	**State/Country**
Month/Day/Year of Graduation (must complete with full date)	**Degree**	
Post Graduate Training		
Internship	**Name of Program**	
Residency	**Name of Program / Current PGY**	
Fellowship	**Name of Program**	
ECFMG		
Certificate Number	**Month/Day/Year Issued (must complete with full date)**	
License- Louisiana State Board of Medical Examiners		
License Number	**Expiration Date**	
License- Federal D.E.A. (University)		
License Number	**Expiration Date**	

Resident/Fellow Agreement

The rotation for ______________________________________ Resident/Fellow, is authorized by the Affiliation Agreement with LSUMC/Tulane and West Jefferson Medical Center and Louisiana Continuing Care Hospital.

Resident/Fellow is affiliated with Dr. _______________________________ in their capacity as clinical faculty member of LSUMSC/Tulane.

The Resident/Fellow's duties include assisting the staff member of hospital rounds, surgery, and consultations in the hospital as delineated in rules and regulations. The Resident/Fellow performs solely at the discretion of the above named staff and is solely assigned to them for the purposes of training by the Chairman of the Department of __________________________ at LSUMC/Tulane.

Resident/Fellow shall comply with all requirements and responsibilities established by the medical staff bylaws, rules and regulations, hospital policies applicable to such. Each Resident/Fellow granted privileges must agree, in writing, prior to the exercise of any privileges to comply with all of the above.

______________________________	______________________________
Resident/Fellow's Signature	**Effective Date**

West Jefferson Medical Center
Signature Sheet

Orientation: I acknowledge that I have attended the required general orientation and understand my responsibilities in accordance to the policies and procedures of West Jefferson Medical Center.

Signature Date

Compliance Program and Code of Conduct: I acknowledge receipt of information about West Jefferson Medical Center's Compliance Program and Code of Conduct. I will abide by its principles and all associate laws, regulations and policies. I understand it is my responsibility to report any concerns or suspected misconduct that I am aware of.

Signature Date

Information Technology Acceptable Use Policy: I acknowledge receipt of information and agree to abide by the Information Technology Acceptable Use Policy. I realize that West Jefferson Medical Center's security software may record and store for management use of the electronic mail messages I send and receive, the entered address of any site that I visit and any network activity in which I transmit or receive of any find of file. I acknowledge that I have no right or expectation of privacy in my usage of West Jefferson Medical Center's Internet Access Infrastructure. I understand that any violation of this policy could lead to disciplinary action or even criminal prosecution.

Signature Date

Duty Hours: I acknowledge that I am required to keep an accurate log of the hours I work and are to submit those hours upon request from the Graduate Medical Education Department at West Jefferson Medical Center.

Signature Date

Request to Transfer: I acknowledge that all transfers into and out of the program are to go through the supervising physician.

Signature Date

Access to Protected Health Information
Acknowledgement Form

Name______________________________ **SS#**______________________

Department__________________________________ **Entity**___________________

I acknowledge that I have read, understand, and agree to abide by EPHI General Security Policy.

I agree to limit my use, disclosure or request of Protected Health Information to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

I agree to only access, use, or request Protected Health Information that is needed for a treatment relationship, patient care function or legitimate business purpose for which I am assigned.

____ ______________
Signature Date

____ ______________
GME Coordinator Signature Date

ATTESTATION CORPORATE COMPLIANCE

CODE OF CONDUCT

I certify that I have been provided a copy of, and have read and understand the West Jefferson Medical Center Code of Conduct. I agree to abide by the Code of Conduct during the entire term of my employment by West Jefferson Medical Center. I acknowledge that I have a duty to report an alleged or suspected violation of the Code of Conduct to West Jefferson Medical Center. Further, I certify that I will report any potential violation of which I become aware promptly to West Jefferson Medical Center through its Administration, Compliance Officer, and/or Compliance Hotline.

COMPLIANCE TRAINING

I certify that I have been provided one (1) hour of General Compliance Training. I understand my responsibilities related to compliance related issues as an employee of West Jefferson Medical Center.

I certify that I have read and am in agreement with each of the items within this Attestation document unless noted below:

____

Printed Name	Signature	Date

CONFLICT OF INTEREST STATEMENT

To the best of my knowledge and belief, neither I nor any member of my family has any ownership or other financial interest in any entity that does business with West Jefferson Medical Center.

I will not engage in any activity on behalf of West Jefferson Medical Center that will bring about personal financial gain, other than the salary and other compensation that I receive from West Jefferson Medical Center.

I will not engage in any outside employment or other activity that will distract from the full time and attention that I must devote to the position and responsibilities of which I was hired by West Jefferson Medical Center.

If any of the above statements are not true, please explain:

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If I find that the above information has changed at any time, I will immediately notify my direct supervisor.

Printed Name	Signature	Date