Lallie Kemp Medical Center
RESIDENT APPLICATION

PERSONAL DATA	**Last Name:**__________ **First Name:**__________ **MI**___ **Mailing Address:** __________ __________ **Telephone:** __________ **Social Security #:** __________ **Date of Birth:** __________ **Place of Birth:** __________ **Citizenship:** __________ **Marital Status:** __________ **Name, Address, Phone Number & Relationship of Next of Kin:** __________ __________
PROGRAM & LEVEL (Years Completed)	**Program:** __________ **PGY Level:** 1 2 3 4 5 6 (Please Circle) **Begin Rotation:** __________ **End Rotation:** __________
EDUCATIONAL HISTORY A continuous and inclusive list of internships, residencies, fellowships, staff positions, leave of absences, research, employment, etc must be provided from medical school graduation through current training (use separate sheet if necessary)	<u>Name</u> <u>Location</u> <u>Dates</u> (mm/dd/yyyy) <u>Degree</u> **College:** ______ ______ ______ ______ **Medical School:** ______ ______ ______ ______ **Post-Grad. Training:** ______ ______ ______ ______ **Medical School Graduation Date (mm/dd/yyyy):** __________ **Initial Specialty:**__________ **Current Specialty:**__________
BEEPER & LICENSE NUMBERS	**Beeper Number:** __________ **ID #** __________ **La. Medical/Dental License Number:** __________ **(Provide Copy)** **DEA and/or Facility DEA License Number:** __________ **Medicaid Provider Number:** __________ **ECFMG Certificate #:** __________ **Date:**__________ **NPI #:**__________
HEALTH STATUS	**Yes** ___ **No** ___ **Are you aware of any health impairments which would affect your ability In terms of skill, attitude or judgment to perform resident duties/ Privileges? If yes, please provide written explanation on a separate sheet.**
SIGNATURES & DATES	__________ **Signature of Applicant** **Date** __________ **Signature of Program Director** **This is to acknowledge that LKMC Policies and Procedures were received:** __________ **Signature of Applicant** **Date** Rev 07/12 DK

Lallie Kemp Hospital

Resident Signature Sheet

CERTIFICATION OF SIGNATURE

I certify that the signature below is my professional signature
to be used by the Pharmacy

Print Name:	
Signature:	
Initials	
Louisiana Medical License Number	
State Narcotics Number:	N/A
Federal DEA Number:	N/A
Medicaid Provider #:	N/A
NPI #	
Date:	
Service:	

Copy of completed form to:
Pharmacy Department
Health Information Manager

Louisiana State University Health Sciences Center

Computer Account Application

All applicants *must* complete the following: (please print)

Last Name: ____________ First Name: ____________ Middle Initial: ____ Prefix: ____

Place of Birth: (City, State if U.S. City, Country if not U.S.): ____________

Date of Birth: ___/___/___ Sex: ______ Social Security Number: ____________

Home Street: ____________ Home Phone Number: ____________

Home City, State, Zip: ____________

X LSUHSC: Faculty / Staff / Student
__ B-1 Business Visitor: (Attach Approved B-1 Application)
__ Visiting Student, U.S. Citizen
__ Visiting Student: Non U.S. Citizen: (Visa Status: ______)
__ External Affiliation: ____________

School / Department / Hospital / Agency: LSUHSC Job Title: House Officer

Section: Emergency Medicine LSUHSC Phone Number: 504-702-2287

LSUHSC Address: 2001 Tulane Avenue, D&T Bldg., 2nd Floor City, Zip: New Orleans, 70112

By signing this application, I agree to the following:

- I acknowledge that I am accountable for all activity attributable to my logon ID. Accordingly, I will not share my logon ID and I will guard my password.
- I will use my logon ID to perform authorized activities only (i.e., to carry out employment, contract, or school-related responsibilities).
- If I abuse or gain unauthorized access to computer resources, I understand that LSUHSC may immediately revoke my computer privileges and report my conduct to law enforcement authorities.
- I understand that, upon significant change in relationship with LSUHSC (e.g., change of department/agency, job function, etc.), my access to computer resources will be subject to review and appropriate modification.
- I understand that, upon termination of employment, non-renewal of contract, or loss of active LSUHSC student status, LSUHSC may delete my logon ID and my data.
- I understand the importance of privacy and confidentiality of information and in particular patient information, student records, and employee personal data. I pledge to access and handle all sensitive data with the appropriate care and precautions.
- I will abide by CM-42, the University policy regarding appropriate use of its network infrastructure. The policy can be found at: http:www.lsuhsc.edu/no/administration/cm/cm-42.htm.
- I understand that LSUHSC does not guarantee the privacy of e-mail.

Signature of Applicant: ____________ Date of Application: ____________

Applicant's computer supporter must complete the following:

Network

Login Script: ____________, Home Directory: ____________

Global Groups: ____________

Applications

__ Email
__ Citrix
__ Document Imaging
__ Med-Solution Pharmacy
__ CLIQ
__ Lab Tracker
__ Visual Cactus
__ DSS
__ PS Accounting
__ PS Asset Mgmt
__ PS Purchasing
__ PS Accts Payable
__ PS Grants
__ PS Student
__ PS HR
__ Kronos

__ SMS: Sign-On TCL: ____________, Group Access: ____________

__ SMSNET: TCL: ____________, Group Access: ____________

__ Other: Attach Additional Documentation if necessary: ____________

Supervisor Signature: ____________ Print Name/Title: ____________

Authorizing Signature: ____________ Print Name/Title: ____________

Computer Supporter's Signature: ____________ Support Group: ____________

Revised: 11/28/2006

LSU MEDICAL CENTER HEALTH CARE SERVICES DIVISION
Lallie Kemp Hospital
52579 Highway 51 South
Independence, La. 70446

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release to Lallie Kemp Hospital, its Medical Staff and its representatives, any and all information and documentation, including, but not limited to quality assurance actions, malpractice actions, disciplinary actions or concerns, and substance abuse records that might be material to an evaluation of my professional competence, judgment, ethics, and other qualifications for residency appointment and clinical privileges requested.

I hereby release from liability Lallie Kemp Hospital its Medical Staff and its representatives for acts performed in good faith in connection with the solicitation and evaluation of the above records and documents bearing on my application and my credentials and other qualifications for residency appointment and clinical privileges requested.

I hereby, also, release from liability any and all individuals and organizations that provide to Lallie Kemp Hospital, or its medical staff in good faith information and material concerning my professional competence, judgment, ethics, and other qualifications for residency appointment and clinical privileges requested.

______________________ ______________________________

Date **Signature of Resident**

____

Printed Name

INTERN/RESIDENT
ACKNOWLEDGEMENT OF NOTICE

I, the undersigned, acknowledge that I have received and read the following notice to Physicians by this Hospital.

NOTICE TO PHYSICIANS:

Medicare payment to hospitals is based in part on each patient's principal and secondary diagnosis and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

____________________ **Date**

______________________________ **Signature of Physician**

Physician's Name: ______________________________
(Please Print)

Department: Emergency Medicine

Louisiana Medical/Dental License No.: ____________________

Effective Date License Initially Issued: ____________________

INTERN/RESIDENT
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_________________________ Date

_________________________ Signature of Physician

Physician's Name ____
(Please print)

Department: ____

La. Medical License: ____________________________________

Effective Date License Initially Issued: ______________________