INSTRUCTION SHEET FOR
RESIDENT APPLICATION

Please complete the enclosed application form in its entirety providing complete addresses for all institutions along with the following items:

1. Current Curriculum Vitae
2. Copy of Driver's License or Passport
3. TB Skin Test
4. Current Flu Vaccination
5. ECFMG

If we can be of any assistance to you, please do not hesitate to contact the Medical Staff Services office at 225-231-5667.

Sincerely Yours,

Hope Price

Hope Price
Medical Staff Coordinator

Enclosures: Application
Resident Evaluation Form
HIPPA Forms
Confidentiality Forms
Authorization for Release

APPLICATION FOR RESIDENTS/FELLOWS

Personal Data Date_____

Name, Last_____ First_____ Middle_____

Mailing Address_____

Telephone#_____ Beeper #_____ Cell #_____

Social Security #_____ Date of Birth_____ Birthplace_____

Marital Status:_____ Sex_____Citizenship:_____

Education

	Name	Address	Dates	Degree
College	_____	_____	_____	_____
Medical School	_____	_____	_____	_____
Post Grad Training	_____	_____	_____	_____

Licensure and Program Information
(Please provide copies of medical license, driver's license and ECFMG certificate if applicable.)

Driver's License# _____ State_____ Expiration Date_____

Medical License# _____ State_____ Expiration Date_____

☐Reciprocity ☐Examination ECFMG # (if applicable) _____

PGY Level_____ Beginning Rotation Date_____ Ending Rotation Date_____

Program Name and Address_____

_____

Department Name and Phone # _____

In requesting approval at Woman's Hospital, I agree to abide by its Corporate and Medical Staff Bylaws, Rules and Regulations and Policies as applicable.

_____
Signature of Resident/Fellow Applicant Date

_____
Signature of Program Director Date

By my signature, I attest that this resident/fellow possesses the skills and competencies of his/her appropriate training year as described in the program requirements.

Approvals

_____
Signature of Site Director or Chief of Staff Date

_____
Signature of CEO or Designee Date

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release to Woman's 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 Woman's 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 Woman's 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.

Signature of Resident/Fellow Date

_____

Printed Name

Woman's Hospital
Baton Rouge, Louisiana

Non-Employee Confidentiality Agreement

Name: _____
(Last, First, MI – Please Print)

Position: _____

Organization: _____

Supervisor's Name: _____

I understand that my association, duties or educational assignments with the above named organization may entail access to information from Woman's Hospital that is not generally available or known to the public. Such information includes but is not limited to patient, customer, member, provider, group, physician, employee, financial, and proprietary information, whether oral or recorded in any form or medium.

Woman's Hospital has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information. In the course of my organization's business relationship with Woman's Hospital, I may access or be exposed to confidential patient information, even though it may not be directly involved with the services/assignments I am performing.

In consideration of, and as a condition to, my organization's business relationship with Woman's Hospital, I will hold any and all information ("confidential information") in strictest confidence. I hereby agree that such information is confidential and belongs to Woman's Hospital. I further agree that information developed by me, alone or with others, that uses information from Woman's Hospital may also be considered confidential information that belongs to Woman's Hospital.

As an employee/student/agent/vendor/visitor of the above named organization, I hereby agree that I will not access confidential information from Woman's Hospital except when legitimately required in the performance of my assigned duties.

No confidential information shall be disclosed except to fulfill their obligations to Woman's Hospital or to authorized representatives of Woman's Hospital. I will not sell, share, discuss, assign, transfer, or otherwise disclose any confidential information outlined above with any other individuals or business entities during or beyond my affiliation with Woman's Hospital. I will not use the confidential information for any purpose other than providing the mutually agreed upon services.

I understand that any breach of confidentiality may result in disciplinary action, including immediate discontinuation of my use of the system or access to restricted areas, and termination of my engagement as an external resource at Woman's Hospital and possible legal action.

_____ _____
Signature Date

_____ _____
Witness Date

WOMAN'S HOSPITAL
RESIDENT/FELLOW EVALUATION FORM

Resident/Fellow:_____ PGY Level:_____

Please base your evaluation of the following factors on demonstrated performance compared to that reasonably expected of a resident/fellow with a similar level of training, experience, and background.

	ACCEPTABLE	UNACCEPTABLE
Attendance		
Basic Medical Knowledge		
Professional Judgment		
Sense of Responsibility		
Clinical Competence		
Technical Skill		
Motivation and Interest		
Willingness to Learn		
Peer Relationships		
Attitude toward Patients		
Attitude toward Preceptors		
Surgical Skills and Judgement		
Clinical Assessment		
Clinical Judgement		

Comments:_____

_____

_____

_____

_____

_____

_____

Program Director Signature Date