Our Lady of the Angels Hospital
House Staff Application Form

Applicant's Printed Name: _____ M.D./D.O. Today's Date: _____

I . IDENTIFYING INFORMATION

Last Name:	First Name:	Middle Name:	Other Name(s) Used in Training
Gender: ☐Male ☐Female	Social Security Number:		Date of Birth:
Birth Place (City/State/Country):		Emergency Contact and Phone Number: Relationship:	

II . ADDRESS

Home Address: (No P.O. Boxes)	Cell Phone Number: Pager Number:
City, State, ZIP Code	E-mail Address:

III . SPECIALTY SERVICE

Please indicate the Specialty Service to which you wish to belong:

☐ Family Medicine ☐ Ophthalmology ☐ Other: _____

IV. LICENSURE (Please provide ALL applicable)

Type:	Number:	Expiration:
Louisiana Medical/Dental License		
Federal DEA License		
NPI Number		
Other State Licensure:		

V. MALPRACTICE CARRIER - CURRENT

PLEASE ATTACH a copy of the face sheet reflecting Name of Insured, Carrier Name, Policy Number, Coverage Amounts, and Effective Dates.

VI. MEDICAL EDUCATION

Medical School:		Degree Received (MD, DO, etc.):	Month/Year of Graduation:
Mailing Address:		Dates Attended: From (mm/yy)	To: (mm/yy)
City:		State and Country:	Zip code:
Phone:	Fax:		

VII. ECFMG CERTIFICATION

ECFMG #:	Date Issued:	Expiration Date:	Valid Indefinitely ☐

*****Please attach copy of ECFMG certificate to this application*****

VIII. POST GRADUATE TRAINING

List EVERY postgraduate training program you have been associated with beginning with your current institution/program. Please explain any gaps in your training.
(**Attach additional sheets if necessary. Reference this Section Number **)

1) CURRENT Institution: LSU HSC/LSU Rural Family Medicine Residency Program	Dates Attended: Start Date (07/01/2018): Expected Graduation (mm/yy): 06/30/2021
Program/Specialty Family Medicine	Type: ☐ Internship, if separate from residency ☒ Residency ☐ Fellowship
Mailing Address: 420 Avenue F	Program Director: Emilio Russo, MD
City: Bogalusa State: LA	Phone: 985-735-6735
Country & Zip Code: USA, 70427	Fax: n/a

2) Previous Institution (if applicable):	Dates Attended: From: (mm/yy) To: (mm/yy)
Program/Specialty:	Type: ☐ Internship, if separate from residency ☐ Residency ☐ Fellowship
Mailing Address:	Program Director:
City: State:	Phone:
Country & Zip Code:	Fax:
Did you successfully complete the program? ☐Yes ☐No *If "NO", please state reason:*	

3) Previous Institution (if applicable):	Dates Attended: From: (mm/yy) To: (mm/yy)
Program/Specialty:	Type: ☐ Internship, if separate from residency ☐ Residency ☐ Fellowship
Mailing Address:	Program Director:
City: State:	Phone:
Country & Zip Code:	Fax:
Did you successfully complete the program? ☐Yes ☐No *If "NO", please state reason:*	

4) Previous Institution (if applicable):	Dates Attended: From: (mm/yy) To: (mm/yy)
Program/Specialty:	Type: ☐ Internship, if separate from residency ☐ Residency ☐ Fellowship
Mailing Address:	Program Director:
City: State:	Phone:
Country & Zip Code:	Fax:
Did you successfully complete the program? ☐Yes ☐No *If "NO", please state reason:*	

5) Previous Institution (if applicable):	Dates Attended: From: (mm/yy) To: (mm/yy)
Program/Specialty:	Type: ☐ Internship, if separate from residency ☐ Residency ☐ Fellowship
Mailing Address:	Program Director:
City: State:	Phone:
Country & Zip Code:	Fax:
Did you successfully complete the program? ☐Yes ☐No *If "NO", please state reason:*	

CURRENT PROGRAM COORDINATOR INFORMATION

☐ **Program Coordinator: Susan Pieno**

Phone: 985-735-6735 **FAX: n/a** **E-mail: spieno@lsuhsc.edu**

XI. QUESTIONS

ATTACH a DETAILED letter of explanation for any questions to which the answer is "YES". Please reference the Section, Title, and Question Number on all attachments.

A) DISCIPLINARY ACTIONS

1.	Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, voluntarily or involuntarily relinquished, or are any actions pending?	☐YES ☐NO
2.	Have your privileges at any medical facility ever been suspended, diminished, revoked, not renewed, or are any actions pending, or are your current privileges the subject of focused review, or any other kind of peer review, proctoring, or special supervision?	☐YES ☐NO
3.	Have you ever voluntarily or involuntarily resigned your privileges/membership from any medical facility or medical practice?	☐YES ☐NO
4.	Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any medical organization, or are any actions pending?	☐YES ☐NO
5.	Has your Drug Enforcement Administration license ever been limited, suspended, revoked, or voluntarily or involuntarily relinquished, or are any actions pending?	☐YES ☐NO
6.	Has a regulatory body for medical practice sanctioned you?	☐YES ☐NO
7.	Have you ever been convicted of or are you currently named in a criminal proceeding?	☐YES ☐NO
8.	Have you ever been denied acceptance or membership or been deselected from an HMO, PPO, or other health care entity?	☐YES ☐NO
9.	Have you ever been excluded from participation in the Medicare, Medicaid, or CHAMPUS programs on the basis of fraudulent federal program billing practices?	☐YES ☐NO
10.	Have you ever been excluded from participation in the Medicare, Medicaid, or CHAMPUS programs on the basis of any criminal violations of federal program regulations or requirements?	☐YES ☐NO

B) MALPRACTICE UPDATE

1.	Regardless of whether you have been named individually as a defendant, has a law suit(s) ever been filed or has a judgment(s)/settlement(s) ever been made in a case involving your actions or omissions as a physician or as an employee or employer, or are any such suits, judgments, or settlements pending?	☐YES ☐NO
2.	Has your professional liability insurance policy been cancelled or renewal refused?	☐YES ☐NO
3.	Have limitations ever been placed on the scope of your professional liability insurance coverage, or have you received notice of intent to so limit your coverage?	☐YES ☐NO

XII. Applicant Attestation

By my signature, I declare that all information provided by me or on my behalf, within this application or in conjunction with this application, has been submitted truthfully and accurately. I understand that it is my sole responsibility to immediately submit an update of this questionnaire to the Medical Staff Office in the event that any answer(s) to any of these questions become inaccurate or incomplete while my application is in process. I also understand that failure to do so may constitute cause to deny entry into a clinical rotation at Our Lady of the Angels Hospital. ("OLOAH")

I hereby authorize the release to OLOAH, its employees, officers, directors and any other representatives, and its medical/dental staff, any and all information and documentation, recommendations, reports, statements or other information in connection with verification and evaluation of information pertaining to my application or otherwise relating to my clinical competence, professional conduct, character, ethics, behavior or other matters bearing on my qualifications, AND I extend absolute immunity to, release from any and all liability and agree not to sue OLOAH., or any other representative of OLOAH, or its Medical/Dental Staff, for their acts performed in connection with evaluating my initial application or continuing peer review and my credentials and documents.

I hereby further authorize and consent to the release by OLAH or any of its representatives, or its Medical/Dental Staff to other hospitals, medical/dental staffs, educational programs, medical associations and any other persons with a need to know of any and all information OOLAH and its medical/dental staff may have concerning my clinical competence, professional conduct, character, ethics, behavior or other matters bearing on my qualifications.

I extend absolute immunity to, release from any and all liability and agree not to sue OLOAH or any other representative of OLOAH or its Medical/Dental Staff, for providing the above-referenced information and documents.

In making this application, I acknowledge that I have received and agree to be bound by the OLOAH Medical/Dental Staff Bylaws and Rules and Regulations as may be amended from time to time, and I agree to be bound by the terms thereof in all matters relating to the consideration of my application.

Applicant's Signature: _____ **Date:** _____

Applicant's Printed Name: _____

ROTATOR ACKNOWLEDGEMENT AGREEMENT

I am making application to Our Lady of the Angels Hospital, Inc., for permission to accept a clinical rotation at the Hospital to gain practical experience in the practice of medicine.

I agree to abide by the following terms and conditions:

1. I acknowledge and agree that I am covered by professional medical liability insurance as required in the Affiliation Agreement between the School and Hospital. Proof of Insurance coverage is required prior to the start of the clinical rotation.
2. I acknowledge and agree that my activities will be under the supervision and control of my sponsoring practitioner, and I will take no independent action at the facility related to patient care which is not authorized within the clinical activities established by Our Lady of the Angels Hospital, Inc. "Medical-Dental Staff Bylaws and Rules and Regulations", Policies for Clinical Rotations and the Affiliation Agreement.
3. I agree to ensure that all chart entries made by me on any patient record are personally reviewed and countersigned by my sponsor within the time limit prescribed by Hospital rules and regulations and/or applicable medical education norms and customs.
4. I acknowledge that I am not a fully trained practitioner or allied health professional, am not an employee of Our Lady of the Angels Hospital, Inc., and I agree to make no representation to the contrary to anyone. Further, I agree that at all times while I am at the facility, I will wear appropriate identification as may be designated by the Hospital reflecting my status.
5. I agree that at all times while at the facility, I will observe all rules and regulations of Hospital as set forth in its bylaws, policies and regulations, as may be amended, including but not limited to random drug testing, and to fully comply with the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and the *Ethical and Religious Directives for Catholic Health Care Services*, as amended. I further agree to abide by all federal, state and local laws and regulations including, but not limited to, any applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") regarding the protected health information I may encounter during the term of this agreement.
6. I acknowledge that the Hospital may, at any time with or without cause, terminate its consent to permit me to continue the clinical rotation at the facility, and I understand such termination can be made immediately if requested by my sponsoring practitioner or other authorized individual.
7. I agree to hold all confidential, proprietary, and privileged information concerning the operation of Hospital or its patients in confidence.
8. I agree to conform to the standards and practices established by the School while at Hospital.
9. I agree to not submit for publication any material relating to my clinical experience without the prior written approval of Hospital.
10. I certify that I have never been excluded, debarred, suspended, or otherwise ineligible to participate in federal programs including Medicare and Medicaid.
11. I hereby authorize the release to Our Lady of the Angels Hospital, Inc. its employees, officers, directors and any other representatives, and its medical/dental staff, any and all information and documentation, recommendations, reports, statements or other information in connection with verification and evaluation of information pertaining to my application or otherwise relating to my clinical competence, professional conduct, character, ethics, behavior or other matters bearing on my qualifications.
12. I extend absolute immunity to, release from any and all liability and agree not to sue Our Lady of the Angels Hospital, Inc., or any other representative of Our Lady of the Angels Hospital, Inc., or its Medical/Dental Staff, for their acts performed in connection with evaluating my initial application or continuing peer review and my credentials and qualifications.
13. I hereby further authorize and consent to the release by our Lady of the Angels Hospital, Inc. or any of its representatives, or its Medical/Dental Staff to other hospitals, medical/dental staffs, educational programs, medical associations and any other persons with a need to know of any and all information the hospital and medical/dental staff may have concerning my clinical competence, professional conduct, character, ethics, behavior or other matters bearing on my qualifications, AND I extend absolute immunity to, release from any and all liability and agree not to sue Our Lady of the Angels Hospital, Inc. or any other representative of Our Lady of the Angels Hospital or, its Medical/Dental Staff, for providing the above-referenced information and documents.
14. I fully understand that any misstatements in, or omission from, my application constitute cause for denial of acceptance for clinical rotation or cause for summary dismissal from the Graduate Medical Education Program.
15. I understand that I have a continuing obligation to update the information in my application and report any changes in the information provided.
16. By my signature, I declare that all information provided by me or on my behalf, within my application or in conjunction with my application, has been submitted truthfully and accurately to my best knowledge and belief.

_____ _____

Applicant's Signature Date

_____ _____

Applicant's Printed Name Applicant's Telephone Number

_____

Applicant's Address

FMOLHS
INFORMATION SECURITY AND CONFIDENTIALITY AGREEMENT

FRANCISCAN MISSIONARIES OF OUR LADY HEALTH SYSTEM

Patient, financial, and other business-related information in any form, verbal, electronic or printed, is a valuable asset, and is considered private and sensitive. Employees, physicians, physician office staff, consultants, vendors, contracted agency staff, and students may have access to confidential information in the performance of their duties. Those charged with this responsibility must comply with information confidentiality/security policies in effect at FMOLHS and its affiliates (collectively referred to as "FMOLHS" in this Agreement). This agreement applies regardless of the method of access used.

As a condition to my association with FMOLHS, I agree to maintain the confidentiality of FMOLHS's confidential and proprietary information, including but not limited to:

1. Patient Information, including demographic, health and financial information;
2. Private information about members of FMOLHS's workforce (e.g. social security numbers, dates of birth, banking information, employment records, home addresses, and telephone numbers);
3. FMOLHS's proprietary and confidential information (e.g., trade secrets, patient lists, prices, professional fees, reimbursements, computer systems technology, profit and loss data, investments, sources of academic or research funding, proprietary research information, strategic and business plans, vendor/third party payor contracts, vendor lists, and peer review information).

As a condition to my access to FMOLHS information systems and my association with FMOLHS, I agree to the following conditions:

1. I understand that FMOLHS has the right to monitor data and information that are stored or communicated via the FMOLHS network and systems to ensure that all applicable laws and FMOLHS policies are followed. As such, I understand that, except as otherwise stated herein, there is no expectation of privacy on my part for any device that is connected to the FMOLHS network or systems or for any access to/from such systems. I also understand that all access may be monitored on the FMOLHS network.
2. I agree to abide by all present and future confidentiality/security policies and procedures including but not limited to the Mobile Device Policy; The Security Policies for the FMOLHS Information Network, The FMOLHS Internet/Email Access and Email Usage Policy, and the Physician Practice IS Services Policy (as relevant).I understand that such policies and procedures are available on the Intranet or have been provided directly to me.
3. I will not operate or attempt to operate computer equipment without specific authorization.
4. I will not demonstrate the operation of computer equipment or applications to anyone without specific authorization.
5. I agree to maintain a unique password, known only to myself to access the system to read, edit and authenticate data. I understand that my unique password constitutes my electronic signature and that it should be treated as confidential information. I agree not to share my password with any other individual or allow any other individual to use the system once I have accessed it. I understand that I may change my password at any time.
6. I agree only to access the patient, financial, and/or other FMOLHS business-related information needed for the performance of my duties and responsibilities. Note: Internet access and appropriate usage is governed by a separate policy.
7. I will contact my FMOLHS representative, my supervisor, Chief Information Security Officer (CISO), or the FMOLHS IS department if I have reason to believe the confidentiality and security of my password has been compromised.
8. I will not disclose any portion of the computerized systems to any unauthorized individuals. This includes, but is not limited to, the design, programming techniques, flow charts, source code, screens, and documentation created by employees, outside resources, or third parties.
9. I will not disclose any portion of the patient's record except in accordance with FMOLHS's policies related to the release of patient records
10. I understand that applications are available outside of the FMOLHS network via various remote access methods (i.e. VPN, Citrix, and/or Web), and I agree to abide by the following when accessing FMOLHS computer systems from remote locations:
    a. I will only access FMOLHS computer systems from remote locations if I am authorized to do so.
    b. I will use discretion in choosing when and where to access FMOLHS computer systems remotely in order to prevent inadvertent or intentional viewing of displayed or printed information by unauthorized individuals.
    c. I will use proper disposal procedures for all printed materials containing confidential or sensitive information.

d. I understand that if I choose to use my personal equipment to access FMOLHS computer systems remotely, it is my responsibility to provide internet connectivity, configure firewall and virus protection appropriately, and to install any necessary software/hardware. FMOLHS is not responsible if the installation of software necessary for accessing FMOLHS computer systems remotely interferes or disrupts the performance of other software/hardware on my personal equipment.

e. I understand that by using my personal equipment to access FMOLHS computer systems that my computer is a de facto extension of the FMOLHS network while connected, and as such is subject to the same rules and regulations that apply to FMOLHS owned equipment.

11. *I agree to* report any activity which is contrary to FMOLHS policies or the terms of this agreement to my supervisor, the CISO, or a security administrator.
12. If I will be using a mobile device to access the FMOLHS network or network services (through a personally-owned or FMOLHS-owned device) that include, but is not limited to, email, VPN, or other remote access capabilities, I will allow FMOLHS limited control of my mobile device for the protection of FMOLHS data and its assets. For this context a mobile device is currently identified as a mobile phone, tablet, or other miniaturized computing system. This limited control can include the enforcement of a password/pin and/or remote wiping of the mobile device in the event of loss or theft or other factors that may present a risk of harm to the FMOLHS network, its data, or applications.
13. I agree to comply with all relevant FMOLHS Compliance and IS Policies, including but not limited to the Mobile Device Policy.
    a. In the event of loss or theft of my device, I agree to the remote wiping of all content on my mobile device, including any personal information I may have stored on the device, such as (but not limited to) photos, videos, and other content stored on the hard drive of the device.
    b. In the event of an investigation or inquiry by the internal compliance department or the government, or in the event of litigation, I agree to provide FMOLHS and/or its affiliate(s) with access to my device to copy and retain information related to the investigation, inquiry or litigation. I understand that FMOLHS will take reasonable steps to limit access to personal information, such as using key word searches to identify relevant material.

I understand that I must sign this Agreement as a precondition to issuance of a computer password for access to the FMOLHS network and/or patient information and that failure to comply with the preceding provisions will result in formal disciplinary action, which may include, but will not be limited to, termination of access, termination of employment in the case of employees, termination of agreements in the case of contractors, or revocation of clinical privileges in the case of medical staff members, taken in accordance with applicable medical staff by-laws, rules and regulations.

USER GETTING THE ACCESS – PLEASE PRINT & COMPLETE THIS SECTION:

Name of User: _____
(Please print the Firstname, Middle Initial, and Lastname)

User Signature: _____ Date: _____

User e-mail Address: _____

Last 4 digits of SSN: _____ Date of Birth: ___/___/___
*** For identification purposes when calling the IS Support Center. This information is securely guarded. ***

Contract Company Name: _____ Contract Company Phone: (___)-___-____

FMOL HEALTH SYSTEM SPONSOR (Management Employee) – PLEASE COMPLETE THIS SECTION:

FMOLHS Requestor Name (Printed): _____ Date: _____

FMOLHS Requestor Signature: _____
As FMOLHS Sponsor by signing above you acknowledge that all appropriate paperwork has been signed.

End Date: All End Dates are scheduled for June 12th and will extend when approved during the annual Access Audit Portal (AAP). If this person is no longer part of FMOLHS, please open a footprints ticket for FMOLHS IS Provisioning Team to disable their access.

CONTRACT PERSONNEL: Signed forms for contract Personnel should be

1. **Submitted by the FMOL Health System Sponsor (Management Employee).** (A management employee should submit the request for access. Contract employees or non-management personnel cannot submit requests for access.)
2. **Attached to a IS Ticket** (Fax can be used: 225-765-9904)

Our Lady of the Angels Hospital
House Staff Teaching Program Letter

Name of Resident or Fellow: _____

Institution and Program Specialty: LSU School of Medicine, Rural Family Medicine

Year in program at time of OLOAH rotation: PGY 1, 2, 3

Dates of rotation at OLOAH: July 1, 2018 – June 30, 2021

I, Emilio A. Russo, MD, the undersigned program director, hereby certify the following:

- The above named participant is enrolled and in good standing at LSU Rural Family Medicine Residency Program (Institution/Program).
- The participant has no physical or mental health problems that would interfere with the conduct of medical care as delineated in the written descriptions of the roles, responsibilities, and patient care activities of the participants of medical education programs.
- The participant has fulfilled immunization requirements, documented updated tetanus status, and testing for TB and/or other such infectious diseases as required by federal, state law or regulation, or hospital regulations.
- The participant is covered by professional liability insurance provided by school or program.
- The participant has other insurance to include health insurance, disability insurance, statutory worker's compensation insurance, employer's liability insurance and comprehensive general liability insurance.
- The participant is competent and qualified to perform patient care activities as delineated.
- A representative from the teaching institution has made arrangements for an active member of Our Lady of the Angels Hospital's medical staff to serve as a sponsoring physician who has agreed to supervise the participant during his/her tenure at the Hospital.

_____ _____

Signature of Program Director & Date **Signature of Participant & Date**

Emilio A. Russo, MD _____

Name of Program Director (Print) **Name of Participant (Print)**

Institution Address:

LSU Rural Family Medicine Residency Program
420 Avenue F

Bogalusa, LA 70427