Baton Rouge General
A Community of Caring

Rotating Resident Application Packet

2018-2019 Academic Year

Welcome to Baton Rouge General Medical Center! We look forward to having your rotate at our facilities.

This application is a fillable PDF file. **Please type your answers and email your completed application packet and all required attachments to your program coordinator. Handwritten applications will not be processed. Required fields on each form are outlined or underlined in red.** If a field does not apply to you, such as "ECFMG certificate date", please enter N/A.

Incomplete packets cannot be processed and will result in the delay of the start of a rotation.

All items listed below must be completed and attached in order for your application to be processed.

- ✓ Application for rights
- ✓ Authorization for release of information
- ✓ Systems Access and Confidentiality Agreement
- ✓ Resident request for privileges
- ✓ Access card application
- ✓ Non-Workforce Confidentiality Agreement

Office of Graduate Medical Education Contact Information

GME@brgeneral.org
3600 Florida Blvd.
Baton Rouge, LA 70806

Director of GME – Jennifer Burch (Jennifer.Burch@brgeneral.org) or 225-381-7736

GME Coordinator – Stacy Higgerson (Stacy.Higgerson@brgeneral.org) or 225-387-7010

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RESIDENT/FELLOW APPLICATION FOR RIGHTS
WHILE IN TRAINING AT BATON ROUGE GENERAL MEDICAL CENTER

Last name _____ First name _____ M.I. _____ Maiden name _____

Birthplace _____ D.O.B. _____ Sex _____ Social Security number _____

Home address _____ City _____ State _____ Zip _____ Cell phone # _____

Email address _____ Marital status ☐S ☐M ☐W ☐D Name of spouse _____

Medical school attended _____ Date of graduation _____ Degree (MD, DO, etc) _____

Residency program entering _____ Level of training _____ List initial residency program if different or N/A _____

Are you a foreign medical graduate? ☐ Yes ☐ No If yes, list ECFMG certificate date: _____

Emergency contact: Name _____ Relationship _____ Phone number _____

Address _____ City _____ State _____ Zip _____

Scrub size (choices are S, M, L, XL, XXL, XXXL): Top _____ Bottom _____

LA medical license #: _____ Expiration date: _____ NPI # _____
DEA license #_____ LA controlled substance licensure # _____

I understand that this application is not complete if the following applicable documents are not attached:

ECFMG certificate	☐ Yes ☐ No ☐ N/A	Louisiana medical license	☐ Yes ☐ No
DEA license	☐ Yes ☐ No ☐ N/A	ERAS application	☐ Yes ☐ No
PPD documentation	☐ Yes ☐ No	Flu vaccination	☐ Yes ☐ No
Immunization record	☐ Yes ☐ No	LA controlled substance license	☐ Yes ☐ No ☐ N/A

☐ **I accept.** By selecting the "I accept" button, you are signing this application electronically. You agree your electronic signature is the legal equivalent of your manual signature on this application.

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release to Baton Rouge General Medical Center, 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 Baton Rouge General Medical Center, 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 release from liability any and all individuals and organizations that provide to Baton Rouge General Medical Center, 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.

A photo static copy of this page constitutes my written authorization to request documentation.

Date

Signature

Printed Name

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SYSTEMS ACCESS AND CONFIDENTIALITY AGREEMENT

Student/Resident Access

Security, data integrity and confidentiality are matters of concern for all persons who have access to General health Systems (GHS) information systems. Measures must be taken to ensure that any such computerized systems in use at GHS and where applicable, GHS off-site subsidiaries and affiliates can only be accessed by authorized users. As an authorized user of the GHS information systems, you have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information.

As a condition to receiving access to information, **I, (Please Print)** _____ the undersigned, understand and agree to comply with the following items:
First Name Middle Initial (Required) Last Name

1. Privileges granted to Students must be granted for periods of one school session. Students must have their privileges reauthorized by the sponsoring department head every School session.
2. An authorized network and/or application ID and password are required for computer user access to all Information Services controlled computer resources. Each ID must be directly identifiable to a specific individual, who is accountable for all actions traceable to that ID. Each individual assigned or given responsibility for an ID is sole owner of that ID and must sign the Vendor Request Form acknowledging an understanding of his/her responsibility relative to the General Health System's computer resources.
3. Regardless of the circumstances, passwords must never be shared or revealed to anyone else besides the authorized Student. To do so exposes the authorized Student to responsibility for actions that the other party takes with the disclosed password. All passwords must be immediately changed if they are suspected of being disclosed, or known to have been disclosed to anyone besides the authorized Student.
4. You will be held accountable for any/all security violations traceable to your ID/password. Audit logs of access, and system messages may be admissible as evidence should litigation occur.
5. When providing computer networking services, General Health System does not provide default message protection services such as encryption. Accordingly, no responsibility is assumed for the disclosure of information sent over General Health System networks and no assurances are made about the privacy of information handled by General Health System internal networks. In those instances where session encryption or other special controls are required, it is the vendor's/contractor's responsibility to make sure that adequate security precautions have been taken. Nothing in the paragraph should be construed to imply that General Health System policy does not support the control dictated by agreements with third parties (such as organizations which have entrusted General Health System with confidential information).

Additional Comments: _____ **Full** SSN required for set up in Paragon.

ACCESS NEEDED: Portal (Pacs, EMR, HCI) Other

USER REQUESTING ACCESS – PLEASE COMPLETE THIS SECTION:

User Signature: _____ Date: ___/___/____ End Date: ___/___/_____

Med or Res Student ID# _____ SSN:____/__/____ DOB: _____/___/_____

Psychiatry Resident

GHS DESIGNATED REQUESTER – PLEASE COMPLETE THIS SECTION:

Requestor Signature: _____ Date: _____

Requestor Name (printed): Stacy Higgerson E-mail: Stacy.Higgerson@brgeneral.org

Phone Number: 225-387-7010

All requests must be scanned and email to the service desk to create a case. ServiceDesk@brgeneral.org

By signing above you acknowledge that all appropriate paperwork has been signed.

7/1/2018-6/30/2019

Baton Rouge General

ACCESS CARD APPLICATION

Badge Number:	**Issue Date:** _____/_____/_____
Employee Name (Last, First, Middle Initial):	
Department: Graduate Medical Education	**Title:** Psychiatry Resident
Supervisor's Name:	**Date of Hire:** _____/_____/_____

SPECIFY ACCESS LEVEL
(Levels to be determined)

❑ Administration	❑ PFS – Vault Room
❑ Ambulance Service	❑ Volunteers
❑ Licensed Professional	❑ Environmental Services
❑ Facilities Management	❑ Pharmacy*
☑ Medical Staff	❑ ER – PFS
❑ Direct Care	❑ Other

❑ Disable Existing Card # _____

TERMS OF USE ACKNOWLEDGEMENT

- Employees agree to use access card only for official business within the department(s) for which they are granted access.
- Employees will not knowingly allow use of their card by anyone else.
- Employees are charged $10.00 for replacement of lost cards.
- Employees will not be issued a replacement card after three lost cards.
- BRGMC reserves the right to revoke access privileges from employees for violation of any of the terms contained in this agreement.

I have read and agree to the terms of use for the acess card issued to me.

Employee Signature/HR Representative: _____ Date:____/____/____

Applicant Name: _____

Primary Privileges

- ✓ Currently granted privileges
  Responsibilities of a Psychiatry Resident
- ✓ Ability to perform a history and physical examination including the history and physical examination as a part of a consultation
- ✓ Ability to perform venipuncture
- ✓ Ability to place a cannula for intravenous infusion in a peripheral vein of the upper extremity of adult patients not receiving hemodialysis
- ✓ Ability to perform basic cardiopulmonary resuscitation
- ✓ Ability to write or dictate progress notes including the final progress note or discharge summary
- ✓ Ability to write diagnostic and therapeutic orders
- ✓ Ability to request consultations by members of the medical staff
- ✓ Ability to perform/participate in ECT

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at the Hospital and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____

Practitioner's Signature Date

Department Chair Recommendation - Privileges

General Health System

NON-WORKFORCE MEMBER CONFIDENTIALITY AGREEMENT

I, the undersigned, understand that, although I am not a member of the workforce of General Health System, ("General Health"), I may acquire certain information during my visit at General Health facilities that constitutes information that must be kept confidential. I understand that General Health's patients expect confidential treatment of their medical information and other protected health information. I understand that I may have access to confidential medical, financial and proprietary operational information pertaining to General Health, its patients, or other persons.

I agree that I will not disclose confidential medical, financial, operational, or personnel related information to any person, corporation or entity unless General Health expressly permits it or unless required by law or legal process. Any disclosure made will be reported immediately to the General Health System Privacy Officer. Confidential information includes, but is not limited to, information relating to any and all medical treatment or protected health information of persons at General Health or affiliated companies, or anyone whose records are obtained by General Health in the course of treating a patient. I agree to treat all financial information as confidential unless I receive explicit instructions to disclose it. I agree that I will not disclose any confidential information of General Health after termination of my relationship with General Health, regardless of the circumstances of the end of my services with General Health, unless I have received prior permission in writing from General Health.

I understand that my entering this agreement is a condition of my continued relationship with General Health and its affiliates.

_____ _____/_____/_____

Signature **Date**

_____ _____

Print Name **Company Name or Affiliation**