LSUHealth
INTERIM LSU PUBLIC HOSPITAL
Graduate Medical Education

LSU

PERSONAL DATA FORM

PLEASE PRINT LEGIBLY OR TYPE

Department: ______________________________ House Officer Level: **(Level you will be in July)** _______________ (Circle One): Internship Residency Fellowship

Training Program Name: ____

Name: ____
Last First Middle

Mailing Address: ____
Street City State Zip

Telephone Number: Beeper Number:

Social Security Number: ___________________________ Citizenship: _____________________________________

Date of Birth: ________________________________ Place of Birth: ____

National Provider Identification (NPI#): ____

Sex: Male_ Female _ Marital Status: S M W D Spouse's Name: ____

Race: (Please check one)
American Native ___Asian or Pacific Islander ___Hispanic ___White ___Black ____

List Person to Contact in case of Emergency: ____

Relationship: __________________________ Telephone Number: ____

PLEASE ATTACH THE FOLLOWING:

___ ACLS Certificate (If Applicable)

___ Copy of Medical License

___ Picture

LSU Health
INTERIM LSU PUBLIC HOSPITAL

LSU

Graduate Medical Education

APPOINTMENT FORM

NAME: ____
Last First Middle Degree

SS#: ________________________ D.O.B. ____/____/_______ NPI#: _______________________

DEPARTMENT: __________________________ SUBSPECIALTY: _________________________

New Appointment: ______ Renewal: ______If Renewal, Did you Transfer from another Department? ______

Termination: _______ Transfer: _______From What Program: _______________________________

HAVE YOU EVER WORKED WITH ANY OTHER LSU ENTITY? __________ IF SO ID# ________

EFFECTIVE DATE: ______________________________

EXPECTED PROGRAM COMPLETION DATE: ______________________________

APPOINTMENT LEVEL: _______________________

BEEPER #: ___________________________ CELL#: __________________________________

SUBMITTED BY: _____________________________ DATE: ____________________

PHONE: _____________________________________

PROGRAM DIRECTOR: ______________________________________

THIS FORM IS TO BE COMPLETED FOR ANY HOUSE OFFICER WHO WILL BE ON CLINICAL ROTATION AT THE MEDICAL CENTER OF LOUISIANA.

Medical Staff Services

House Officers/Fellows
Signature File

Name of Physician: ____
(Please Print)

ILH ID#: ____

School / Department: ____

Cell Number: _________________________ **Beeper Number:** ______________________

DEA License Number: ____

Signature of Physician: ____

LSU Health
INTERIM LSU PUBLIC HOSPITAL

CODE GREY

SEVERE WEATHER PLAN

I hereby acknowledge receipt of the Interim LSU Public Hospital (ILPH) Physicians Disaster Plan for Code Grey Operations Plan. I understand that:

- I am responsible for complying with the ILPH Physician Disaster Plan for Code Grey and the Code Grey Operations Plan,
- I may be assigned to an on-call team by my Department Chairman, Section Chief or Chief Resident
- The ILPH Medical Director has the final authority and responsibility for all assignments for all of the Staff (Medical Staff Members/Interns/Residents/Fellows).

________________________________ ________________________
Printed Name Cell phone Number

____
Local Address City State Zip Code

___________________________________ ______________________
Signature Date

Circle the appropriate status: Intern Resident Fellow

School/Department: _______________________________

Code of Conduct

ACKNOWLEDGMENT

This is to acknowledge that I have read and understand the Interim LSU Public Hospital Medical Staff Code of Conduct.

____
(Print Name)

____
Signature Date

Code of Conduct

ACKNOWLEDGMENT

This is to acknowledge that I have read and understand the Interim LSU Public Hospital Medical Staff Code of Conduct.

____

(Print Name)

____

Signature Date

Environment of Care:
Key Elements

ILH Department of Professional Development
And Clinical Affiliations

Answer Sheet/Certificate of Completion

Participant: ____

Date: ____

Organization/Department/School: ______________________________

Last Four Digits of Social Security Number: ______________________

Circle Correct Answer:

1. T F	6. T F	11. T F	16. T F
2. T F	7. T F	12. T F	17. T F
3. T F	8. T F	13. T F	18. T F
4. T F	9. T F	14. T F	19. T F
5. T F	1. T F	15. T F	20. T F

This sheet will serve as the record of your training. Please fill it out completely and give to your area supervisor. Name must legible on sign in sheet to receive credit, so please print. Any questions, please call Education/Staff Development, at 903-0702.

Rev. 7/09

Louisiana State University Health Sciences Center
Health Care Services Division
Interim LSU Public Hospital

Corporate Compliance Attestation Statements

CODE OF CONDUCT

- This is to acknowledge that I have received ILH Code of Conduct and understand that it is my responsibility to read the entire document to make myself familiar with the content.

HIPAA CONFIDENTIALITY AGREEMENT

- I Agree to comply with ILH's HIPAA policies which include procedures for proper handling of Personal Health Information (PHI), computer passwords and access and confidentiality.
- I acknowledge that my violation of these policies by me may lead to immediate disciplinary action, up to and including the termination of my employment.
- I also acknowledge that my obligation of confidentiality continues to exist when I leave the employ of the LSU system facility.

Corporate Compliance Attestation Statement

- I have attended the mandatory Corporate Compliance training for all new House Staff Officers and understand that I am responsible for being familiar with the Corporate Compliance Program as it relates to my position and to the facility as a whole.
- I understand that I am responsible for following the Corporate Compliance policies and procedures as well as other policies and procedures of the facility.
- I understand that I am responsible for reporting any suspected fraud and abuse practices within this facility.

If I have any questions regarding compliance or HIPAA, I will contact my Coordinator or the ILH Compliance Liaison Officer as soon as possible.

House Officer's name printed____

House Officer's Signature____

Date________________________________