



OUR LADY OF THE LAKE
R E G I O N A L M E D I C A L C E N T E R
Franciscan Missionaries of Our Lady Health System

HOUSE STAFF APPLICATION

Please use the checklist below as a guide for assuring that your application packet is complete. **All items must be completed and attached in order for your application to be processed. Incomplete packets cannot be processed and will result in the delay of the start of a rotation.**

This application is a fillable PDF file. Please type your answers and email your completed application and all required attachments to your program coordinator. Any handwritten application will not be processed. **Applications must be typed.**

Our GME Services Coordinator will email details regarding house staff orientation requirements prior to the start of your rotation. **It is important that residents check email prior to OLOL rotation so that they may receive these details.**

Any housing requests should be submitted directly to your program coordinator a minimum of one month in advance of your OLOL assignment. Please do not contact the OLOL GME office with housing requests. The GME office will work with your program coordinator directly to arrange housing based on the number of housing units allotted for your program.

Please do not hesitate to contact Lisa Loustalot, GME Services Resident Coordinator in the OLOL Academic Affairs Office at 225-765-8769 with questions regarding your application. We look forward to having you train at Our Lady of the Lake.

OLOL House Staff Application Checklist:

- House Staff Application form
- Rotator Acknowledgement Agreement form
- Rotator Data Sheet
- Pharmacy Signature Page
- Resident Photo/Video Use Agreement
- Housing Questionnaire
- Policy Acknowledgment
- Computer Order Entry Acknowledgment
- Current CV or resume
- Copy of ECFMG Certificate- *if applicable*
- Proof of Professional Liability Insurance
- Teaching Program Letter form
- Systems Access and Confidentiality Agreement form
- Proof of TB Skin Test with Copy of Test Results
- Resident Head Shot for OLOL ID Badge (*in jpg format*)

Our Lady of the Lake Regional Medical Center

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: <input type="checkbox"/> Male <input type="checkbox"/> 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		Residency E-mail Address:	
		Personal Email Address:	
<i>*Provide the email address that you check most often and will receive all residency training related email.</i>			
III . SPECIALTY SERVICE			
Please indicate the Specialty Service to which you wish to belong:			
<input type="checkbox"/> Emergency Medicine <input type="checkbox"/> ENT <input type="checkbox"/> Surgery <input type="checkbox"/> Anesthesia <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Plastic Surgery			
<input type="checkbox"/> Orthopedic Surgery <input type="checkbox"/> Psychiatry <input type="checkbox"/> OMFS <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Dermatology <input type="checkbox"/> Other: _____			
IV. LICENSURE (Please provide ALL applicable)			
<u>Type:</u>	<u>Number:</u>	<u>Expiration:</u>	
Louisiana Medical/Dental License			
Federal DEA License			
NPI Number			
Other State Licensure:			
V. MALPRACTICE CARRIER - CURRENT			
<u>PLEASE ATTACH</u> a copy of the face sheet reflecting Name of Insured, Carrier Name, Policy Number, Coverage Amounts, and Effective Dates. **Institution may provide separately**			
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 <input type="checkbox"/>
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.

(**Attach additional sheets if necessary. Reference this Section Number **)

1) <u>CURRENT Institution:</u>	Dates Attended: Start Date (mm/yy): Expected Graduation (mm/yy):
Program/Specialty:	Type: <input type="checkbox"/> Internship, if separate from residency <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
Mailing Address:	Program Director:
City: State:	Phone:
Country & Zip Code:	Fax:
2) <u>Previous Institution (if applicable):</u>	Dates Attended: From: (mm/yy) To: (mm/yy)
Program/Specialty:	Type: <input type="checkbox"/> Internship, if separate from residency <input type="checkbox"/> Residency <input type="checkbox"/> Fellowship
Mailing Address:	Program Director:
City: State:	Phone:
Country & Zip Code:	Fax:
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If "NO", please state reason:</i>	

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

IX. PROGRAM COORDINATOR INFORMATION

Program Coordinator: _____

Phone: _____ **FAX:** _____ **E-mail:** _____

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?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	Have you ever voluntarily or involuntarily resigned your privileges/membership from any medical facility or medical practice?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	Has your Drug Enforcement Administration license ever been limited, suspended, revoked, or voluntarily or involuntarily relinquished, or are any actions pending?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	Has a regulatory body for medical practice sanctioned you?	<input type="checkbox"/> YES <input type="checkbox"/> NO
7.	Have you ever been convicted of or are you currently named in a criminal proceeding?	<input type="checkbox"/> YES <input type="checkbox"/> NO
8.	Have you ever been denied acceptance or membership or been deselected from an HMO, PPO, or other health care entity?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	Has your professional liability insurance policy been cancelled or renewal refused?	<input type="checkbox"/> YES <input type="checkbox"/> 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?	<input type="checkbox"/> YES <input type="checkbox"/> 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 Lake Hospital, Inc. ("OLOL")

I hereby authorize the release to OLOL, 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 OLOL, or any other representative of OLOL, 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 OLOL 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 OLOL 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 OLOL or any other representative of OLOL or its Medical/Dental Staff, for providing the above-referenced information and documents.

In making this application to the OLOL Medical Education Program, I acknowledge that I have received and agree to be bound by the OLOL 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 _____, a facility of Our Lady of the Lake 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 Lake 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 Lake Hospital, Inc., and am not a member of the Medical Staff, 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 Lake 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 Lake Hospital, Inc., or any other representative of Our Lady of the Lake 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 Lake 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 Lake Hospital, Inc. or any other representative of Our Lady of the Lake 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

2016-2017 Academic Year

Our Lady of the Lake Regional Medical Center

Rotator Data Sheet

Name: _____

Institution/Program: _____

Education Information

Medical School: _____ City, State: _____

Dates Attended: _____ Degree Received: _____

Dental School: _____ City, State: _____

Dates Attended: _____ Degree Received: _____

Graduate Medical Education Information

Please give a continuous and inclusive list of internships, residencies, fellowships, staff positions, leave of absences, gaps in training etc. from your medical school graduation through your current internship, residency or fellowship. Include any gaps in training and the time frame in which those gaps took place. If needed, please attach additional pages.

Beginning Date (Month/Year): _____

End Date (Month/Year): _____

Program: _____

Institution: _____

City and State: _____

Beginning Date (Month/Year): _____

End Date (Month/Year): _____

Program: _____

Institution: _____

City and State: _____

Beginning Date (Month/Year): _____

End Date (Month/Year): _____

Program: _____

Institution: _____

City and State: _____

Beginning Date (Month/Year): _____

End Date (Month/Year): _____

Program: _____

Institution: _____

City and State: _____

Beginning Date (Month/Year): _____

End Date (Month/Year): _____

Program: _____

Institution: _____

City and State: _____

OLOL Pharmacy Signature

(Please keep signature inside box)

Print Name	
Signature	
Initials	

(Please keep signature inside box)

Print Name	
Signature	
Initials	



**OUR LADY OF THE LAKE GRADUATE MEDICAL EDUCATION PROGRAM
RESIDENT PHOTO/VIDEO USE AGREEMENT**

Our Lady of the Lake Hospital, Inc. ("Hospital"), and _____ ("Recipient"), in order to make certain photographs/videotapes available for purposes of education and training of the participants in the graduate medical education program in a manner that complies with ("HIPAA"), hereby agree as follows:

1. The Recipient agrees to use or disclose the photographs/videos only for the purpose of education and training programs authorized by the Hospital's Graduate Medical Education Office, and for no other purpose, except as authorized or required by law.
2. Recipient agrees to use appropriate safeguards to prevent any use or disclosure of the photographs/videos other than as specified in this Agreement.
3. Recipient will report to Hospital's Compliance Officer any unauthorized disclosure of the photographs/videos from Hospital in violation of this Agreement.
4. Recipient will not use the photographs/videos, alone or in combination with other information, to identify the information or contact the individuals from whom it was derived.
5. Recipient will not identify the subject of the photographs/videos with any identifying information, including patient names, social security number, medical record numbers or any other patient identifiers or identifying information.

I fully understand that Hospital is a teaching hospital and that said photograph/video is to be used solely for instruction, teaching and future research for professionals in the field of healthcare as part of the hospital's operations. I understand that Hospital has complete ownership of such pictures, etc. including the entire copyright. Recipient agrees to promptly notify Hospital, as provided above and to follow Hospital's directions with respect to return or destruction of the Photographs/videos. Recipient further understands that misuse of said photograph/video may subject Recipient to disciplinary action in the Graduate Medical Education Program up to and including termination or dismissal from the Program. The parties will use reasonable efforts to discuss alternative ways of providing the Photographs/videos on terms compliant with HIPAA.

Signature for GME Authorized Representative

Name (Please Print) Date:

Recipient Signature

Name (Please Print) Date:

OLOL Housing Questionnaire

My below signature certifies that I had read and have been provided a copy of the OLOL complementary housing policy. I am also requesting housing for myself during my program rotations during the 2016-2017 Academic Year.

I will require OLOL Housing for my rotations during the 2016-2017 Academic Year.

Signature

Print Name

Date

Program

I will not require OLOL Housing for any of my rotations during the 2016-2017 Academic Year.

Signature

Print Name

Date

Program

OLOL Policy Acknowledgement Form

My signature below signifies that I have read and understand the OLOL GME Policies as well as have my own copy of the below policies for the 2016-2017 Academic Year.

OLOL GME Policies:

1. House Staff Scope of Practice GME-RES-07
2. House Staff Participation in Surgical Procedures GME-RES-08
3. Universal Protocol for Operative, Invasive, Sedation, High Risk Procedure Verification; (correct site) OrgClin-040
4. Perioperative Services Surgical Hand Scrub Policy SOS030
5. Employee Dress & Appearance Policy_OO-HR-E-009
6. HIMM04_Incomplete-Delinquent Medical Records Process
7. GME Housing GME-ADM-13

Signature

Print Name

Date

Our Lady of the Lake Regional Medical Center
Resident Computer Physician Order Entry (CPOE) Policy

Mandatory enforcement of the pre-existing rule requiring all residents to participate in computer physician electronic order entry (CPOE) will go into effect on July 1, 2012. Paper, handwritten order from residents will no longer be accepted. A verbal phone order is acceptable when a resident is indisposed (ie, in an emergency or operating room) or outside the facility; but verbal phone orders must encompass less than 20% of all orders placed at our facility.

Starting July 1st, if a resident writes a paper order in a chart, they will be contacted by the floor nurse or charge nurse and told that these are not acceptable orders and that they will need to be entered electronically. If the resident fails to comply or respond, the attending physician will be contacted. If the issue is left unresolved, nursing will contact the medical staff office or GME for guidance.

Resident CPOE usage will be monitored by both GME and the MSO. GME will monitor residents weekly and contact those performing under the above standards. Quality reports will be issued to resident faculty as deemed necessary at the completion of the given rotation.

If a resident has a month in which their CPOE utilization is under 75% they will be contacted and given a warning and must complete further mandatory training. If they have a second month of under utilization of CPOE they will lose ordering capabilities for the remainder of the year while within the OLOLRMC system.

If a resident is reported to the GME or Medical Staff Office for non-compliance, they will receive two warnings and on the third incident, their password and account will be inactivated for the month.

Signature

Print

Date

Our Lady of the Lake Regional Medical Center

House Staff Teaching Program Letter

Name of Resident or Fellow: _____

Institution and Program Specialty: _____

Year in program at time of OLOL rotation: _____

Dates of rotation at OLOL: _____ 2016-2017 Academic Year _____

I, _____, the undersigned program director, hereby certify the following:

- The above named participant is enrolled and in good standing at _____
_____ (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 Lake'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 and Date

Signature of Participant and Date

Name of Program Director (Print)

Name of Participant (Print)

Institution Address:



SYSTEMS ACCESS AND CONFIDENTIALITY AGREEMENT
Supplemental Staff/Contracted Services/Medical Staff

Security, data integrity and confidentiality are matters of concern for all persons who have access to Franciscan Missionaries of Our Lady Health System (FMOLHS) information systems. Measures must be taken to ensure that any such computerized systems in use at FMOLHS and where applicable, FMOLHS off-site subsidiaries and affiliates can only be accessed by authorized users. As an authorized user of the FMOLHS 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. My User ID and password is the equivalent of my **LEGAL SIGNATURE**. I will not share or disclose my password to anyone nor allow anyone to access any FMOLHS system or application using my User ID.
2. I am responsible and accountable for all activities undertaken using my User ID/Password.
3. I will not attempt to learn or use another person's User ID or password.
4. I will not access any system or application using a User ID other than my own.
5. I will access confidential information only as needed by me to perform my legitimate duties at FMOLHS. This means, among other things, that:
 - a. I will not access confidential information that I have no legitimate need to know.
 - b. I will not in any way divulge, copy, release, sell, loan, revise, alter, or destroy any confidential information except as properly authorized within the scope of my employment.
 - c. I will not misuse, carelessly care for or fail to safeguard confidential information.
6. I understand that I have no right or ownership interest in any confidential information referred to in this agreement.
7. It is my responsibility to log out of the system. I will not leave a workstation unattended to which I have logged on.
8. If I have reason to believe that the confidentiality of my User ID has been compromised, I will change my password. I will immediately report any known or suspected breach of the confidentiality of the system or records/data obtained from it to my immediate supervisor.
9. I understand that my User ID will be inactivated upon notification that I am no longer employed, transferred or have no privileges at FMOLHS or when my job duties do not require access to the computerized systems.
10. I understand that the FMOLHS conducts and maintains an audit trail of accesses to patient information that records the User ID, machine name, date/time, and patient identification.
11. My signature below indicates my understanding of the above noted requirements for the use of any User ID that I am assigned, pursuant to my employment, student, medical staff, or contract responsibilities with FMOLHS.
12. **I agree to abide by FMOLHS' policies concerning the use of computers. I understand the computer and all of its accessories are the property of the hospital and are to be used only for hospital business. FMOLHS reserves the right to examine systems, directories, files and their contents at any time.**

USER REQUESTING ACCESS – PLEASE COMPLETE THIS SECTION:

User Requesting Access Signature: _____ Date: _____

Last 4 digits of SSN: _____ *** For identification purposes only.*

Contract Company Name: LSUHSC Contract Company Phone: 225-765-8769

End Date: All End Dates are June 12th and will extend when approved during the Access Audit Portal. If the employee's access needs to be disabled before this date, please log a ticket to IS to disable the access.

FMOLHS EMPLOYED REQUESTER – PLEASE COMPLETE THIS SECTION:

FMOLHS Requestor Name (Printed): Lisa Loustalot Date: _____

FMOLHS Requestor Signature: _____

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

FMOLHS Support Center Provisioning Phone: 866-532-4772 Fax Number: 225-765-9904

Revised 01/30/2013 BT

2016-2017 Academic Year