



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

(BR-BASED) RESIDENT HOUSE STAFF RECREDENTIALING 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 Re-Credentialing Application Checklist (BR-Based Residents):

- Teaching Program Letter form
- Resident Updated Information Sheet
- Resident Photo/Video Use Agreement
- Policy Acknowledgment
- Computer Order Entry Acknowledgment
- Current CV or resume
- Proof of Professional Liability Insurance
- Proof of TB Skin Test with Copy of Test Results

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:



OUR LADY OF THE LAKE

REGIONAL MEDICAL CENTER

Franciscan Missionaries of Our Lady Health System

Please update your preferred contact information for your file.

<i>Name</i>	Another name you would prefer to go by: _____
<i>Program</i>	
<i>Address</i>	
<i>Cell</i>	<i>Please include carrier (ex: AT&T, Sprint, Verizon)</i>
<i>Pager</i>	<i>Do you use your pager # on a daily basis? Yes <input type="checkbox"/> No <input type="checkbox"/></i>
<i>Email</i>	<i>Please provide the address that you check most frequently, as this address will be used to communicate important messages on delinquent medical records and updates from medical staff.</i>
<i>When you are on-call, how would prefer to be contacted by nursing staff?</i> <i>My pager # <input type="checkbox"/> My cell # <input type="checkbox"/></i>	

Today's date: _____



**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:

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

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