LSUHealth
INTERIM MEDICAL CENTER
Graduate Medical Education

LSU

PERSONAL DATA FORM

PLEASE PRINT LEGIBLY OR TYPE

Department: _____ House Officer Level: _____ (Circle One):
(Level you will be in July)
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

LSUHealth
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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.

LSUHealth
INTERIM MEDICAL CENTER

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: _____

LSUHealth
INTERIM MEDICAL CENTER

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: _____

LSU HEALTH SYSTEM
HEALTH CARE SERVICES DIVISION
INTERIM LSU PUBLIC HOSPITAL

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

LSUHealth
INTERIM MEDICAL CENTER

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_____