

Graduate Medical Education

PERSONAL DATA FORM

PLEASE PRINT LEGIBLY OR TYPE

(Circle One): Internship Residency Fellowship

Department: _____

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

Name: _____
Last First Middle

Mailing Address: _____
Street City State Zip

Social Security Number: _____ Citizenship: _____

Date of Birth: _____ Place of Birth: _____

National Provider Identification (NPI#): _____

Beeper Number: () Cell Number: () Email: _____

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



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#: _____

EMAIL: _____

PROGRAM COORDINATOR: _____ DATE: _____

PROGRAM DIRECTOR: _____

THIS FORM IS TO BE COMPLETED FOR ANY HOUSE OFFICER WHO WILL BE ON CLINICAL ROTATION AT INTERIM LSU HOSPITAL.



Graduate Medical Education

**House Officers/Fellows
Signature File**

Name of Physician: _____
(Please Print)

ILH ID#: _____

School / Department: _____

Cell Number: _____ **Beeper Number:** _____

DEA License Number: _____

Signature of Physician: _____



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CODE GREY

SEVERE WEATHER PLAN

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

- I am responsible for complying with the ILH 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 ILH 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: _____



Medical Staff Services & Graduate Medical Education

Code of Conduct

ACKNOWLEDGMENT

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

(Print Name)

Signature

Date



Medical Staff Services & Graduate Medical Education

GENERAL ORIENTATION KEY ELEMENTS

ACKNOWLEDGMENT

This is to acknowledge that I have read and understand the Interim LSU Hospital General Orientation Key Elements.

(Print Name)

Signature

Date