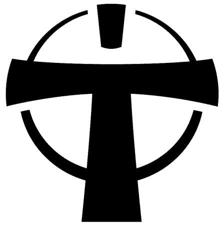

OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER

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 may result in the delay of the start of a rotation. Our GME Services Coordinator will send out details regarding house staff orientation requirements prior to the start of your rotation.

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 try and accommodate requests to the extent possible, as space is limited.

Please do not hesitate to contact the OLOL Academic Affairs Office at 225-765-7730 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
- ☐ Systems Access and Confidentiality Agreement form
- ☐ Teaching Program Letter form
- ☐ Proof of Professional Liability Insurance
- ☐ Copy of ECFMG Certificate- *if applicable.*
- ☐ Current CV or resume
- ☐ Rotator Data Sheet
- ☐ Proof of TB Skin Test with Copy of Test Results

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: ☐Male ☐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	E-mail Address:

III . SPECIALTY SERVICE

Please indicate the Specialty Service to which you wish to belong:

☐ Emergency Medicine ☐ ENT ☐ Surgery ☐ Anesthesia ☐ Internal Medicine ☐ Plastic Surgery

☐ Orthopedic Surgery ☐ Psychiatry ☐ Other: ________________________

IV. LICENSURE (Please provide ALL applicable)

Type:	Number:	Expiration:
Louisiana Medical/Dental License		
Federal DEA License		
NPI Number		
Other State Licensure:		

V. MALPRACTICE CARRIER - CURRENT

PLEASE ATTACH 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

Please attach copy of ECFMG certificate to this application

VIII. POST GRADUATE TRAINING

List <u>EVERY</u> <u>postgraduate</u> training program you have been associated with <u>beginning with your current</u> institution/program.

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

1) CURRENT Institution:	Dates Attended: Start Date (mm/yy): Expected Graduation (mm/yy):
Program/Specialty:	Type: ☐ Internship, if separate from residency ☐ Residency ☐ Fellowship
Mailing Address:	Program Director:
City: State:	Phone:
Country & Zip Code:	Fax:

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

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

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

#	Question	Answer
1.	Has your license to practice medicine in any jurisdiction ever been limited, suspended, revoked, voluntarily or involuntarily relinquished, or are any actions pending?	☐YES ☐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?	☐YES ☐NO
3.	Have you ever voluntarily or involuntarily resigned your privileges/membership from any medical facility or medical practice?	☐YES ☐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?	☐YES ☐NO
5.	Has your Drug Enforcement Administration license ever been limited, suspended, revoked, or voluntarily or involuntarily relinquished, or are any actions pending?	☐YES ☐NO
6.	Has a regulatory body for medical practice sanctioned you?	☐YES ☐NO
7.	Have you ever been convicted of or are you currently named in a criminal proceeding?	☐YES ☐NO
8.	Have you ever been denied acceptance or membership or been deselected from an HMO, PPO, or other health care entity?	☐YES ☐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?	☐YES ☐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?	☐YES ☐NO

B) MALPRACTICE UPDATE

#	Question	Answer
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?	☐YES ☐NO
2.	Has your professional liability insurance policy been cancelled or renewal refused?	☐YES ☐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?	☐YES ☐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:____

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: ____

- -

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	

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: ____________2013-2014 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:

____

____

____

Revised: 2/27/2012

OUR LADY OF THE LAKE
REGIONAL MEDICAL CENTER
Franciscan Missionaries of Our Lady Health System

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 Our Lady of the Lake Regional Medical Center (OLOLRMC) information systems. Measures must be taken to ensure that any such computerized systems in use at OLOLRMC and where applicable, OLOLRMC off-site subsidiaries and affiliates can only be accessed by authorized users. As an authorized user of the OLOLRMC 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 name)** ______________________________ the undersigned, understand and agree to comply with the following items:

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 OLOLRMC 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 OLOLRMC. 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 OLOLRMC when my job duties do not require access to the computerized systems.

10. I understand that the OLOLRMC 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 OLOLRMC.

12. **I agree to abide by OLOLRMC's 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. OLOLRMC reserves the right to examine systems, directories, files and their contents at any time.**

Contract User Signature: ______________________ Date: ______________________
Start Date: ______________________ End Date*: ______________________
Company Name: ______________________ Last 4 digits of SSN** ______________________

OLOLRMC Requestor Signature: ______________________ Date: ______________________

OLOLRMC Requestor Name (printed): ______________________
By signing above you acknowledge that all appropriate paper work has been signed and filed with Human Resources.
**Must be specified, not to exceed 6months ** For identification purposes only.*