Policy 4.4.2.1. June 2020

VISITING RESIDENTS 2 – CLINICAL ROTATION APPLICATION AND CHECKLIST

Instructions: Complete and return the application and checklist to the program in which you desire to do a clinical rotation. Incomplete application packets will not be processed and will be returned to the applicant. Packet must be submitted 30 days (US citizens) or 120 days (visa holders) prior to rotation start date. Expedited applications will incur a charge of 100.00, which must accompany packet.

☐Check this box if DIO's pre-approval of this clinical rotation has been obtained during pandemic. Do not pass this step until pre-approval has been obtained.

Full name as it appears on SSN Card				
Credentials	☐ MD ☐ DO ☐ Other _____			
Social Security Number				
Home Address				
Phone Numbers	Work _____ Home _____ Mobile _____			
Email Address				
Medical School				
Medical School Graduation Date (MM/DD/YYYY)				
Current Program				
Sponsoring Institution				
Current Program Address	Address 1			
	Address 2			
	City, State			
	Country, Postal Code			
Dates of Current Program	Began: _____ Expected Completion: _____			
Current Specialty PGY Level		Number of post graduate years completed including current training year.		
Program Director				
Program Director & Program Coordinator Contact Information				
Initial Program (first yr out of medical school)				
Rotation Request at UTHSCSA	Specialty		Dates	
UT Hosting Program's PD name (printed)				
UT Hosting Program's PD Signature				
Today's Date				

Please mail this application form, checklist, $100.00 (US) application fee (non-refundable), and required documents to the program in which you desire to do a clinical rotation.

The hosting UTHSCSA program will be notified once the application packet has been approved by the GME office, and the program will have final approval of the requested rotation and dates.

Policy 4.4.2.1. June 2020

VISITING RESIDENTS 2 – CLINICAL ROTATION APPLICATION AND CHECKLIST

Print Full Name _____

	Curriculum Vitae (Please explain any gaps in dates.)
	Medical School Documents: ☐ LCME-Accredited Medical School Graduates – provide the following items: Copy of Diploma or Final Medical School Transcript (with "conferred on" dates) Texas State Medical License (if applicable) **OR** Texas Physician in Training Permit Copy of J-1 Visa (if applicable) -OR- ☐ Non-LCME-Accredited Medical School Graduates – provide the following items Copy of Diploma (original and English translation) or Final Medical School Transcript (with conferred on dates) Valid ECFMG certificate Full and Unrestricted license Texas Medical License or Texas Physician In Training Permit Copy of J-1 Visa (if applicable)
	Letter from resident's Program Director, co-signed by the DIO or Director of GME addressing the following: ☐ Name of sponsoring institution and current ACGME or AOA accredited training program of the resident ☐ Authorization and eligibility to pursue elective experiences ☐ Statement of desired clinical rotation(s) including curricular requirements and length of rotation ☐ Name of person assuming responsibility for resident at UTHSCSA ☐ Financial source of stipend & benefits during training at UTHSCSA ☐ Current level of training ☐ Dates resident began and completed Medical School ☐ Date resident began residency training and anticipated completion date ☐ Brief description of resident's prior clinical experiences ☐ Statement that resident is in good standing in the residency program
	Additional documentation required. Please attach. ☐ Evidence of passing USMLE Steps 1 and 2 or COMLEX Steps 1 and 2 ☐ Evidence of health insurance (copy of certificate required) ☐ Proof and source of payment of malpractice insurance (professional liability insurance) during rotation (copy of certificate required) ☐ Ethics and HIPAA Training: Provide proof of training from home program ☐ Evidence of passing a UTHSCSA Security Background Check ☐ Signed Voluntary Disclosure of Social Security Number form ☐ Complete the Confidentiality/Security Acknowledgement Form ☐ Complete the Housestaff Data Sheet ☐ Evidence of completing the UHS restraint training (attach Test) ☐ Copy of Program Letter of Agreement (PLA)
	$100 (US) Application fee – non-refundable –certified check made payable to the Office of Graduate Medical Education at UTHSCSA

Reviewed and approved by the Designated Institutional Official for Graduate Medical Education

_____ _____/_____/_____

Signature Date

Packet forwarded to program on _____/_____/_____ by _____

Texas Physician in Training Permit or Texas Medical License # _____ and date of expiration _____ .

The University of Texas Health Science Center at San Antonio

NOTICE FOR VOLUNTARY DISCLOSURE OF SOCIAL SECURITY NUMBER

School of Medicine Residents

Disclosure of your social security number (SSN) is requested from you in order for The University of Texas Health Science Center at San Antonio (UTHSCSA) to provide accurate information to the Accreditation Council of Graduate Medical Education (ACGME) for the purpose of tracking the educational progress of the residents, to provide accurate information to affiliated hospitals for Medicare reporting, and to submit a roster of residents to the Texas Higher Education Coordinating Board. No statute or other authority requires that you disclose your SSN for that purpose. Failure to provide your SSN, however, may result in the inability of ACGME to make important accreditation decisions regarding UTHSCSA's residency programs; may result in your being denied the opportunity to complete clinical rotations; and, may result in the institution's not being considered for funds allocated for Graduate Medical Education. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable laws.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information The University of Texas Health Science Center at San Antonio collects about you. Under Sections 552.021 and 552.023 of the *Texas Government Code*, you are entitled to receive and review the information. Under Section 559.004 of the *Texas Government Code*, you are entitled to have The University of Texas Health Science Center at San Antonio correct information about you that is held by The University of Texas Health Science Center at San Antonio and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that The University of Texas Health Science Center at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the *Texas Government Code*) and rules. Different types of information are kept for different periods of time.

You may send any requests to:
The Office of the Vice President/Chief Financial Officer
By mail to: 7703 Floyd Curl Drive, San Antonio, TX 78229-3900
By e-mail to: PublicInfo@uthscsa.edu
By fax to: (210) 567-7027
In person at: Academic and Administration Building, Room 442

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CONSENT FOR RELEASE

I **consent** for the release of my social security number for the stated purposes above.

Print Name:

Signature:

Date:

Please return form to
Graduate Medical Education * 7703 Floyd Curl Drive MC 7790 * San Antonio, Texas 78229-3900

Confidentiality/Security Acknowledgement

The University of Texas Health Science Center at San Antonio (UTHSCSA) has a legal and ethical responsibility to safeguard the privacy of all patients and protect confidentiality and security of all health information. During your employment or affiliation with UTHSCSA you may hear information related to a patient's health or read or see computer or paper files containing confidential health information, whether or not you are directly involved in providing patient services. You may also create documents containing confidential patient information, if it is part of your job description and/or as directed to do so by your supervisor.

As part of your employment or affiliation with UTHSCSA, you must strictly adhere to the following regarding confidentiality and security of patient information:

- ✓ *Confidential Health Information.* I will regard patient confidentiality as a central obligation of patient care. I understand that all information, which in any way may identify a patient or which relates to a patient's health, must be maintained in the strictest confidence. Except as permitted by this Acknowledgement, I will not at any time during or after my employment or affiliation speak about or share any patient information with any person or permit any person to examine or make copies of any patient reports or other documents that I come into contact with or which I create, except as allowed within my job duties or by patient authorization.

- ✓ *Permitted Use of Patient Information.* I understand that I may use and disclose confidential patient information only to other providers of health care services, if the purpose of the disclosure is for treatment, consultation, or referral of the patient. If my job description allows, I may also disclose information for payment and billing purposes and/or internal operations, such as use for internal quality studies and for internal education activities.

- ✓ *Prohibited Use and Disclosure.* I understand that I must not access, use or disclose any patient information for any purpose other than stated in this Acknowledgement. I may not release patient records to outside parties except with the written authorization of the patient, the patient's representative, or for other limited or emergency circumstances. Special protections apply to mental health records, records of drug and alcohol treatment, and HIV related information. I must neither physically remove records containing patient information from the provider's office, clinic, or facility, nor alter or destroy such records. Personnel who have access to patient records must preserve their confidentiality and integrity, and no one is permitted access to health information without a legitimate, work-related reason.

  I also agree to immediately report to my supervisor or to the UTHSCSA Privacy Officer any non-permitted disclosure of confidential patient information that I make by accident or in error. I agree to report any use or disclosure of

confidential patient information that I see or know of others making that may be a wrongful disclosure.

- ✓ *Safeguards.* In the course of my employment or affiliation if I must discuss patient information with other healthcare practitioners in the course of my employment or affiliation, I will use discretion to ensure that others who are not involved in the patient's care cannot overhear such conversations. I understand that when confidential patient information is within my control, I must use all reasonable means to prevent it from being disclosed to others except as permitted by this Acknowledgement.

  Protecting the confidentiality of patient information means protecting it from unauthorized use or disclosure in any format, oral/verbal, fax, written, or electronic/computer.

- ✓ *Computer Security.* If I keep any identifiable patient information on a personal digital assistant (PDA), laptop, or other electronic device, I will ensure that my supervisor knows I am using it and has approved such use. I agree not to send patient information in an e-mail unless my supervisor directs me to do so in an emergency. I will not attempt to access information by using a user identification code or password other than my own, nor will I release my user identification code or password code to anyone or allow anyone to access or alter information under my identity. I will ensure that my virus protection software is updated on a routine basis (once per week) and that I back up any confidential information using approved back up procedures.

- ✓ *Physical Security.* I will take all reasonable precautions to safeguard *confidential* information. These precautions include using lockable file cabinets, locking office doors, securing data disks, tapes or CDs, using a password protected screen saver, etc. I agree to store my electronic media in recommended containers and store back up media in approved locations.

- ✓ *Return or Destruction of Information.* If my employment or affiliation with UTHSCSA requires that I take patient information off the UTHSCSA campus or off the property of UTHSCSA affiliates, I will ensure that I have UTHSCSA's or the other facility's permission to do so. I will protect patient information from unauthorized disclosure to others, and I will ensure that all patient information is returned to the appropriate facility.

  Unless specifically stated in my job description, I am not authorized to destroy any type of original patient information maintained in any medium, i.e., paper, electronic, etc.

- ✓ *Termination.* When I leave my employment or affiliation or complete my training or residency at UTHSCSA, I will ensure that I take no identifiable patient information with me, and I will return all patient information in any format to the

UTHSCSA or other appropriate facility. If it is not original documents, but rather my own personal notes, I must ensure that such information is destroyed in a manner that renders it unreadable and unusable by anyone. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality and security of patient information and to return or destroy any such information in my possession.

- ✓ *Violations.* I understand that violation of this Acknowledgement may result in corrective action, up to and including termination of my employment or affiliation. In addition, violation of privacy or security regulations could also result in fines or jail time.

- ✓ *Disclosures Required by Law.* I understand that I am required by law to report suspected child or elder abuse to the appropriate authority. I agree to cooperate with any investigation by the Department of Health and Human Services or any oversight agency, such as to help them determine if UTHSCSA is complying with federal or state privacy laws.

  I understand that nothing in this Acknowledgement prevents me from making a disclosure of confidential patient information if I am required by law to make such a disclosure.

  I understand that if I believe in good faith that UTHSCSA has engaged in conduct that is unlawful or otherwise violates clinical or professional standards, or that the care, services, or conditions provided by the UTHSCSA potentially endangers one or more patients, workers, or the public, a disclosure of confidential information may be made, but only to the appropriate public authority and/or to the attorney retained by me for the purpose of determining legal options with regard to the suspected misconduct.

My signature, on the following page, acknowledges that I have read the terms and conditions of this Acknowledgement. The signature page will be maintained by my department supervisor.

NOTE: To access specific policies regarding privacy or security issues, please refer to the *Handbook of Operating Procedures* (HOP), available at http://www.uthscsa.edu/hop2000/. Security policies are located in Chapter 5 and privacy policies in Chapter 11.

Confidentiality/Security Acknowledgement
Signature Page

By my signature below, I acknowledge that I have read the terms and conditions of the Confidentiality/Security Acknowledgement. I am maintaining the three-page acknowledgement for my own records.

Signature:

Please choose one: Choose your status

Printed name:

Date:

Work Phone:

Department:

The University of Texas Health Science Center at San Antonio
Housestaff Data Sheet

Name: _____
(Last) (First) (Middle) (Gender)

Date of Birth: _____ Social Security#: _____

UTHSCSA Program Name: _____

Emergency Contact Name: _____ Contact Phone: _____

Race: please read descriptors before choosing.

- ○ White
- ○ Black-African American
- ○ Asian
- ○ American Indian or Alaskan Native
- ○ International (on a visa)
- ○ Native Hawaiian or Other Pacific Islander
- ○ Unknown / Not Reported

Ethnic Origin: *(optional)**

Hispanic or Latino: a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

❑ Yes ❑ No

* We are asking for your ethnicity as part of our mission as a Hispanic-serving institution.

Race

American Indian or Alaskan Native: a person having origins in any of the original peoples of North and South America (including Central America), and who maintains a tribal affiliation or community attachment.

Asian: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Phillipine Islands, Thailand, and Vietnam.

Black or African-American: a person having origins of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islander.

White: a person having origins in any of the original peoples of Europe, the Middle East or North Africa.

International denotes a person who is not a citizen or permanent resident of the United States and who is in the country on a temporary basis and does not having the right to remain indefinitely.

Citizenship: _____

Birth city, state, country: _____

City, state, country of High School attended:

Medical Education

Medical School:

_____ (Name) _____ (Location)

Medical School Graduation Date: _____

Degree Type (per diploma): _____

Gold Humanism Award ☐

Alpha Omega Alpha Honor Society ☐

Post Medical School Experience

Please detail your activities each year from your graduation date from medical school through the present. Be sure to include any post-graduate education activities and their locations.

Example:	**ACGME Program**	**Research Year**	**Not Applicable**
2005-2006 PGY-1 Internal Medicine University of Texas Medical Branch	☑	☐	☐
2006-2007 PGY-2 Internal Medicine University of Texas Medical Branch	☑	☐	☐
2007-2008 PGY-3 Internal Medicine University of Texas Medical Branch	☑	☐	☐
2008-2009 Private Practice, Internal Medicine, Galveston, Texas	☐	☐	☑
2009-2010 Private Practice, Internal Medicine, Galveston, Texas	☐	☐	☑
2010-2011 Private Practice, Internal Medicine, San Antonio, Texas	☐	☐	☑
2012-2013 Gastroenterology fellowship, UTHSCSA	☑	☐	☐

Medical School Graduation Year: _____	**ACGME Program***	**Research Year**	**Not Applicable**
_____ (year) (activity, or program)	☐	☐	☐
_____ (year) (activity, or program)	☐	☐	☐
_____ (year) (activity, or program)	☐	☐	☐
_____ (year) (activity, or program)	☐	☐	☐
_____ (year) (activity, or program)	☐	☐	☐
_____ (year) (activity, or program)	☐	☐	☐
_____ (year) (activity, or program)	☐	☐	☐
_____ (year) (activity, or program)	☐	☐	☐

*Sponsoring Institution

If you previously attended an ACGME Program, please list its locations and its Sponsoring Institution.

_____ (program) (Sponsoring Institution)

_____ (program) (Sponsoring Institution)

_____ (program) (Sponsoring Institution)

_____ (program) (Sponsoring Institution)