

## Application for Medical or AHP Students

3200 Providence Drive, Anchorage, AK 99508 or PO Box 196604, Anchorage, AK 99519  
Phone: 907-212-3185 Fax: 907-212-4865

**This application applies to all Medical or Allied Health Professional (AHP) Students seeking to participate in clinical rotation training and education opportunities at Providence Alaska Medical Center.**

- All information must be TYPED or CLEARLY HANDWRITTEN. (Applications that are not legible will be returned)
- No part of the application may be completed by referring to or writing, "See Curriculum Vitae" and/or "See Enclosed/Attached". Each part of the application must be completed in its entirety. Any areas that do not apply to the applicant should be marked with "N/A" leaving no blank areas on the application. (Applications deemed incomplete will be returned for completion)
- If more space is needed, a blank sheet has been provided for your convenience with this application. When using the blank sheet, please make reference to the question being answered.
- All applicants are required to submit the following:**
  - \_\_\_\_\_ This application - completed
  - \_\_\_\_\_ Completed Supervising Physician & Scope of Practice Form for each physician the student will work with
  - \_\_\_\_\_ Copy of current Driver's License or other government issued ID
  - \_\_\_\_\_ Copy of Medical Malpractice Coverage "Face Sheet", showing current coverage of 500,000/1,000,000 or greater.
  - \_\_\_\_\_ Current Curriculum Vitae
  - \_\_\_\_\_ Background Check Authorization
  - \_\_\_\_\_ Computer Account Access Request Form & Confidentiality Agreement

### Personal Information

Last Name		First Name		Middle Name or Middle Initial		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Current Year of Training 1 2 3 4 (please circle one)		Student Specialty <input type="checkbox"/> Medical Student <input type="checkbox"/> ANP <input type="checkbox"/> Nurse Midwife <input type="checkbox"/> Physician Assistant				Clinical Specialty During Rotation	
Dates of Clerkship From: _____ To: _____		Other Names By Which You Have Been Known/Maiden Name				Social Security Number	
Home Street Address				Home City/State/Zip			
Home Phone Number		Home Fax Number		E-Mail Address			
Date of Birth		Birth City/State					
Birth Country		Ethnic Origin (optional)		Citizenship		Permanent Resident Card Number (If applicable)	
Language(s) Spoken by Applicant		Spouse's Full Name (optional)		Marital Status (optional) <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Single			

### Education and Training:

(IMPORTANT REMINDER: No part of the application may be completed by referring to or writing "See Curriculum Vitae" and/or "See Enclosed/Attached" etc.)

#### UNDERGRADUATE EDUCATION:

Name Of Institution		Start MM/YYYY		End MM/YYYY	
Mailing Address City, State Zip					
Type of training/specialty/major		Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain on pg. 11		If yes, what degree was awarded	
Your Program Director/Dean?					
Current Program Director (if applicable)		Phone Number		Fax Number	
		E-Mail Address			

Name Of Institution		Start MM/YYYY	End MM/YYYY
Mailing Address City, State Zip			
Type of training/specialty/major	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain on pg. 11	If yes, what degree was awarded	Your Program Director
Current Program Director (if applicable)	Phone Number	Fax Number	E-Mail Address

**MEDICAL EDUCATION or PROFESSIONAL SCHOOL:** If foreign medical school graduate, submit a copy of ECFMG.

Name Of Institution		Start MM/YYYY	End MM/YYYY
Mailing Address City, State Zip			
Type of training/specialty/major	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain on pg. 11	If yes, what degree was awarded	Your Program Director
Current Program Director (if known)	Phone Number	Fax Number	E-Mail Address

Name Of Institution		Start MM/YYYY	End MM/YYYY
Mailing Address City, State Zip			
Type of training/specialty/major	Was program successfully completed? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain on pg. 11	If yes, what degree was awarded	Your Program Director
Current Program Director (if known)	Phone Number	Fax Number	E-Mail Address

**At any time during your Medical School:**

- A. Were you disciplined, suspended, placed on probation, formerly reprimanded or asked to resign? \_\_\_\_ No \_\_\_\_ Yes
- B. Were you absent from the program for any length of time for any reason? \_\_\_\_ No \_\_\_\_ Yes

*If you answered yes to either question, please explain in detail on page 11 provided with this application.*

**Healthcare Affiliations:**  **N/A** (check here if you have had no prior experience in the healthcare industry)

List all institutions where you have had and/or have an affiliation since completion of your training (residency/fellowship or other) for the past ten-(10) years whichever is less. Indicate affiliation status (Active, Courtesy, Provisional, Temporary, No longer on staff, etc.). Begin with current affiliations and then list past affiliations in chronological order. **(IMPORTANT REMINDER: No part of the application may be completed by referring to or writing "See Curriculum Vitae" and/or "See Enclosed/Attached" etc.)**

Institution		Start MM/YYYY	End MM/YYYY
Mailing Address City, State Zip			
Medical Staff Office Phone Number	Medical Staff Office Fax Number	Medical Staff Office Contact Name	Contact Phone Number
Department/Service practiced at this facility	Staff Category/Title	Reason for discontinuance of affiliation (if applicable)	

Institution		Start MM/YYYY	End MM/YYYY
Mailing Address City, State Zip			
Medical Staff Office Phone Number	Medical Staff Office Fax Number	Medical Staff Office Contact Name	Contact Phone Number
Department/Service practiced at this facility	Staff Category/Title	Reason for discontinuance of affiliation (if applicable)	

**Work History:**  **NIA** (check here if this section does not apply to you)

List all work history experience that is related to healthcare, and/or the medical profession, and/or group or solo practice, etc. since the beginning of your education in healthcare or for the past ten-(10) years, whichever is less. Begin with current and then list past in chronological order. If more room needed, see page 11.  
**(IMPORTANT REMINDER: No part of the application may be completed by referring to or writing "See Curriculum Vitae" and/or "See Enclosed/Attached" etc.)**

Name of Current Practice/Employer		Start MM/YYYY	End MM/YYYY
Mailing Address City, State Zip			
Phone Number	Fax Number	Clinical/Supervisor	Contact Phone Number
Type of Practice	Position Held/Title	Reason for leaving (if applicable)	
Name of Practice/Employer		Start MM/YYYY	End MM/YYYY
Mailing Address City, State Zip			
Phone Number	Fax Number	Clinical/Supervisor	Contact Phone Number
Type of Practice	Position Held/Title	Reason for leaving (if applicable)	

**Military Experience:**  **NIA** (check here if this section does not apply to you) List all military experience since the beginning of your education in healthcare.  
**(IMPORTANT REMINDER: No part of the application may be completed by referring to or writing "See Curriculum Vitae" and/or "See Enclosed/Attached" etc.)**

Status?  Active  Inactive  None  Reserves If Active, where assigned? \_\_\_\_\_  
 If Active, is there an end date to your reserve status?  Yes  No If Yes, When? \_\_\_\_\_

Military Branch	Last Title	Last Rank	Supervisor's Name	
Last Assignment/Facility Complete Address			Date of Assignment	Date of Separation
Phone Number	Fax Number	E-Mail Address	Type of Discharge:	
Military Branch	Last Title	Last Rank	Supervisor's Name	
Last Assignment/Facility Complete Address			Date of Assignment	Date of Transfer
Phone Number	Fax Number	E-Mail Address		

**Explanation of Work History Gap(s):** Any time periods or gaps since beginning medical/professional school of greater than 3 months, which are not explained in the application thus far, must be addressed here. If the application is found to have any unexplained time periods or gaps, the application will not be processed and will be returned to the applicant as incomplete. Please explain any such gaps in detail in the space provided below. (Please use page 11 if additional space is needed.)  
**(IMPORTANT REMINDER: No part of the application may be completed by referring to or writing "See Curriculum Vitae" and/or "See Enclosed/Attached".)**

From Date	To Date	Explanation Of Work History Gap

**Malpractice Coverage** – List all current and past insurance carriers you have had personally or been covered under during the past ten (10) years **and** include a face sheet of any current insurance coverage. Please provide a complete and detailed report of your Malpractice history for the past 10 years using the Malpractice form on page 10 of this application to report each incident as described in question 1, 2 and 3 below.

**(IMPORTANT REMINDER: No part of the application may be completed by referring to or writing "See Curriculum Vitae" and/or "See Enclosed/Attached")**

**IMPORTANT NOTE: Policy requires professional liability insurance in the amount of 500,000/1,500,000 or greater to apply for clinical training experience.**

Name of Present Carrier		How long?	Policy Number	
Complete Address	Phone Number:	Fax Number:	Coverage Amounts	Initial Date / End Date of Coverage

**IF YOU ANSWER "YES," PLEASE PROVIDE DETAILED INFORMATION ON THE ENCLOSED PROFESSIONAL LIABILITY ACTION EXPLANATION FORM (SEE PAGE 10)**

1) In the past ten years, has there been or are there currently, any claims, lawsuits, settlements or judgments against you where you are named, even if not resulting in monetary damages, or have you received any notice of "Intent to File"?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
2) Have you ever had any professional liability insurance coverage canceled, declined or modified (i.e., reduced limits, restricted coverage), or has any renewal ever been refused, or have you voluntarily given up coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
3) If you have ever been a federal, military or tribal employee, have you ever been named as a responsible party in a merited lawsuit against the United States Government that resulted in a financial settlement or payment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
4) Has your professional liability insurance coverage ever been terminated by action of the insurance company?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
5) Have you ever been denied professional liability insurance coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
6) Has any professional liability insurance carrier ever excluded any specific procedures from your coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending
7) Has any insurance company ever imposed a surcharge or additional premium because of your claims history?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pending

## HEALTH STATUS

**IF YOU ANSWER "No," PLEASE PROVIDE DETAILED INFORMATION ON A SEPARATE SHEET (see page 11, added for your convenience).**

Are you able to safely and competently exercise the clinical scope of practice privileges requested?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are your Immunization Records Current to include Non-reactive TB test (0 mm PPD) or medical clearance ( <i>must be current within past 12 months</i> )?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## DISCLOSURE QUESTIONS

All "YES" or Pending answers require a full explanation on a separate page (see page 11, added for your convenience).

Have any of the following been or are currently in process, either on a voluntary or involuntary basis? Are any of the items listed below being: denied, revoked, suspended, reduced, limited, not renewed, relinquished, sanctioned, terminated, reprimanded, censured, excluded, precluded, challenged, disqualified, investigated, cautioned, placed on probation or made subject to any type of conditions, or the subject of an intensified review or court-martialed for disciplinary reasons? This includes any United States jurisdiction or Military Authority.

**IMPORTANT NOTE:** A voluntary relinquishment or voluntary non-renewal is for disciplinary reasons when the relinquishment or non-renewal is done to avoid an adverse action or preclude an investigation or is done while the licensee/registrant/certificant is under investigation related to professional conduct:

Licensure in any state?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Disciplinary action or investigation by a state/county/province, etc. licensing board/authority	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Other professional registration and/or license?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Authorization to practice in any jurisdiction (state, county, borough, parish, etc.)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
DEA/Controlled Substance Registration (Federal and/or State)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Membership or renewal of membership in any hospital medical staff?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever been the subject of an informal or formal hearing process at any hospital?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Clinical Privileges at any hospital or healthcare institution?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Request for any specific Clinical Privileges (aside from ordinary and initial requirements of proctoring)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Board Certification?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Employment?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Any other type of professional sanction?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Participation in any managed care program, IPA, PPO, PHO, MSO, HMO, etc.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Participation in Medicare/Medicaid program, CLIA or any other health plan?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Research under any Federal or private grants?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Academic Appointment or Professional Society?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Relating to the practice of medicine, have you been found guilty of charges filed against you alleging professional misconduct, unprofessional conduct, incompetence or negligence?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever been charged with a felony that did not result in acquittal or dismissal?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever been charged with a misdemeanor that did not result in acquittal or dismissal (other than minor traffic violations)?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Are you currently the subject of any civil or criminal investigation or court process relating to your ability to practice in a safe and competent manner?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever been diagnosed with, treated for, or are you currently inflicted by voyeurism, pedophilia, exhibitionism, or any other sexual behavior disorder? ("Sexual behavior disorder" does not include or imply sexual preference.)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever been adjudicated or declared incompetent?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal or state health insurance program?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever withdrawn your application for appointment, reappointment or clinical privileges at any hospital or health care facility, or for participating provider status in a managed care organization, or resigned before a decision was made by any governing board?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever been the subject of focused individual monitoring related to your clinical competence or professional conduct at any hospital, health care facility, or managed care organization?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you ever been asked to surrender your license to practice any form of healthcare in any state?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Have you been found by a court or agency in Alaska or any other state to have neglected, abused, or exploited a child or vulnerable adult?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending
Does your name appear on a centralized abuse registry in Alaska or any other state?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Pending

I represent that the information provided in or attached to this application is accurate, complete and fairly represents the current level of my training, experience, capability and competence to participate in this training experience. I understand and agree that any misrepresentation, misstatement, or omission from this application whether intentional or not may constitute cause for the immediate cessation of the processing of the application and no further processing shall occur. I understand that in the event permission has been granted prior to the discovery of misrepresentation, misstatement or omission, such discovery may be deemed to constitute automatic termination of this training experience. In either situation, I understand that I may not be entitled to any hearing or appeal rights. I specifically agree to abide by all bylaws, rules and regulations and policies and procedures that are in effect during the time I am on the Providence Alaska Medical Center campus or its associated facilities.

I have had an opportunity to read the Ethical and Religious Directives for Catholic Health Facilities. (See [www.jmahoney.com/ethical\\_and\\_religious\\_directives.htm](http://www.jmahoney.com/ethical_and_religious_directives.htm)). I agree to recognize Providence Health & Services is Roman Catholic sponsored and adheres to the Ethical and Religious Directives. I specifically agree to abide by them if my application is approved. I acknowledge this commitment and will respect these directives in treatment of patients at the Providence Health & Services facilities.

Signature:	Printed Name:	Date:
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(Stamped or representative signatures unacceptable)

***PAMC Attestation and Consent & Release from Liability***

I hereby apply to participate in training and education opportunities approved by the Medical Staff of Providence Alaska Medical Center. In return for my application being considered, I agree to be legally bound to the terms and conditions listed below.

I also understand that in applying for this training and education experience I have the burden of producing adequate information for proper evaluation of my application. I agree to provide the hospital with updated and current information regarding all questions on this application form as such information becomes available and the hospital or its authorized representatives may request such additional information as necessary. I understand failure to produce information as requested will prevent my application form being evaluated and acted upon.

By applying for this training and education opportunity, I accept the following conditions and intend to be legally bound by them, regardless of whether or not I am granted the opportunity requested. These conditions shall remain in effect for the duration of any term of a rotation that I may be granted, and as applicable to third-party inquiries received after I leave PAMC:

1. To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue the Medical Center, its medical staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges or my qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the Medical Center, the medical staff, their authorized representatives, or appropriate third parties.
2. I authorize the Medical Center, its medical staff, and their authorized representatives (i) to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for this training and education experience and (ii) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. In addition, I specifically authorize these third parties to release the information to the Medical Center, its medical staff, and their authorized representatives upon request.
3. I also authorize the Medical Center, its medical staff, and their authorized representatives to release such information to other hospitals, health care facilities, managed care entities, and their agents, and any government or regulatory agencies, including licensure boards who solicit such information for the purpose of evaluating my qualifications pursuant to a request for training, appointment and/or clinical privileges, participating provider status, other credentialing matter, or licensure or regulatory matter.

I acknowledge that (1) a training and education experience at this hospital is not a right of every medical/AHP student who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in the hospital and medical staff bylaws, rules and regulations and policies and procedures; (3) all medical staff recommendations relative to my application are subject to the ultimate action of the hospital Board of Directors, whose decision shall be final; (4) I have the responsibility to keep this application current by informing the hospital, through the CEO and/or his designee of any change in the areas of inquiry contained here in, including but not limited to any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in my medical/AHP student status at my training program; and (6) this and future training and education experiences at PAMC remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the hospital, as evidenced by treatment and continuous care for patients and maintaining appropriate physician supervision during this training and education experience. I agree that I will provide acceptable performance of all responsibilities related thereto as well as the other factors deemed relevant by the hospital.

If granted this training and education experience, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral, (2) refrain from delegating responsibility for diagnoses or care of hospitalized patients to any other practitioner who is not credentialed to undertake the responsibility; (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever required or necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care as needed to all patients assigned to me through my supervising physician in the hospital for whom I have responsibility.

I represent that all of the information provided in or attached to this application is accurate and complete

**Photocopies and/ or facsimile copies of this Authorization will serve the same purpose as the originally executed document.**

<u>Signature:</u>	<u>Printed Name:</u>	<u>Date:</u>
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(Stamped or representative signatures unacceptable)

# Medical Student

## Supervising Physician Form and Scope of Practice

You may complete this section after meeting with your supervising physician. It must be returned to the Medical Staff Office ASAP upon your arrival.

*P l e a s e P r i n t*

Name of Medical Student:	Name of Supervising Physician: <i>(Must be a member of the ACTIVE Medical Staff at PAMC)</i>
Dates of /Rotation:	Department/Specialty:

**Please place a check mark next to the appropriate Scope of Practice.**  
Duties/Privileges may not exceed those outlined in Medical Staff Policy MS 900-040.

<input type="checkbox"/>	<b>1<sup>st</sup> &amp; 2<sup>nd</sup> Year Medical Students</b>	<b>Scope of Practice</b>
These students shall have no independent privileges. They may see patients only under the supervision of the supervising physician. They may observe obstetrical and surgical procedures, after assuring consent has been obtained from the patient.		
These students may write-up history and physicals or progress notes; however, this information will not be entered directly into the patient's chart.		
<input type="checkbox"/>	<b>3<sup>rd</sup> &amp; 4<sup>th</sup> Year Medical Students</b>	<b>Scope of Practice</b>
The medical student may write admission history and physical examinations, write progress notes and write orders. All notes and orders must be read, corrected or agreed with, and signed by the supervising physician. These orders must be co-signed before being implemented.		
Medical students may draw blood, start IV's, or do other limited invasive procedures, only under the direct supervision of the supervising physician.		
The Medical Student may scrub or act as an assistant in surgery or assist in delivering babies under the direct supervision of the supervising physician and only after assuring consent from the patient.		
The patient shall not be charged for services provided by the medical student		

I hereby agree to abide by the selected Scope of Practice and Policies & Procedures of Providence Alaska Medical Center.

\_\_\_\_\_  
Signature of Medical Student

\_\_\_\_\_  
Date

### SUPERVISING PHYSICIAN

I hereby attest to the qualifications of this applicant. As supervising physician, I will assume the responsibility of seeing that the Medical Student will perform only those tasks, which he/she is authorized to perform as authorized by the Providence Health & Services Alaska Region Board. I understand I have full responsibility for all actions or omissions of this student at Providence Alaska Medical Center. I understand I am responsible for the active supervision of this Medical Student and that my responsibilities require me to be ready to assume the care of any patient treated by him/her. Should my supervising relationship with this Medical Student change, I understand I am responsible for all care provided by him/her until I provide written notification to the Medical Staff Office that the relationship has changed. I agree to co-sign all chart notes and orders written (within 24 hours) by the Medical Student. I will write progress notes in the patient charts that will establish the full extent of the Medical Student's involvement with the care of each patient.

\_\_\_\_\_  
Signature of Supervising Physician

\_\_\_\_\_  
Date

When I am unavailable, I will make arrangements to inform the Medical Center and the Medical Student which Active Medical Staff Member has consented to act as a substitute Supervising Physician in my absence. This substitute Supervising Physician will be ready to assume the care of any patient treated by this Student in my absence.

The following Active Staff Members have consented to supervise the Student in my absence or in addition to my agreed supervision:

\_\_\_\_\_  
Name of Covering Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Covering Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Covering Physician

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Covering Physician

\_\_\_\_\_  
Date

## *Allied Health Professional Student Supervising Physician Form and Scope of Practice*

You may complete this section after meeting with your supervising physician. It must be returned to the Medical Staff Office ASAP upon your arrival.

*P l e a s e   P r i n t*

Applicants must check (✓) either ANP, Nurse Midwife, or PA Student Scope of Practice. Supervising physician and ANP, CNM, or PA staff member must be an active member in good standing of the Medical Staff or Allied Health Professional Staff at Providence Alaska Medical Center.

AHP Student's Name

Dates of /Rotation:

Name of Supervising Physician

Department/Specialty

Name of Supervising Allied Health Professional

Department/Specialty

### **Advanced Nurse Practitioner (ANP) Student**

An actively participating ANP Student is authorized to:

- a.) Have unattended contact with the patient for the sole purpose of obtaining a history and performing a physical;
- b.) Dictate histories and physicals in combination with a history and physical examination performed by the supervising physician or ANP with physician counter-signature required;
- c.) Write chart notes and orders, which must be reviewed and counter-signed by the supervising physician and/or ANP prior to being carried out by the nursing staff;
- d.) Perform procedures only under the direct supervision of the supervising physician of the Active Staff and/or the ANP;
- e.) Perform post-partum examinations only under the direct supervision of the supervising physician of the Active Staff and/or the ANP.

### **Nurse Midwife Student**

An actively participating Nurse Midwife Student is authorized to:

- a.) Have unattended contact with the patient for the sole purpose of obtaining a history and performing a physical;
- b.) Dictate histories and physicals in combination with a history and physical examination performed by the supervising physician or CNM with physician or CNM counter-signature required;
- c.) Write chart notes and orders, which must be reviewed and counter-signed by the supervising physician and/or CNM prior to being carried out by the nursing staff;
- d.) Perform procedures only under the direct supervision of the supervising physician of the Active Staff and/or the CNM;
- e.) Perform post-partum examinations only under the direct supervision of the supervising physician of the Active Staff and/or the CNM.

### **Physician Assistant (PA) Student**

An actively participating PA Student is authorized to:

- a.) Have unattended contact with the patient for the sole purpose of obtaining a history and performing a physical.
- b.) Dictate histories and physicals in combination with a history and physical examination performed by their supervising physician or PA with physician counter-signature required.
- c.) Write chart notes and orders, which must be reviewed and counter-signed by the supervising physician and/or PA prior to being carried out by the nursing staff.
- d.) Perform procedures only under the direct supervision of his/her supervising physician of the Active Staff.
- e.) Assist at surgery.

### **RN First Assistant (RNFA) Student**

An actively participating RNFA Student is authorized to:

- a.) Perform surgical procedures **only under the direct supervision** of his/her supervising physician, a member of the Active Staff, to include, site exposure, hemostatis, suturing, tying and administering medications and blood products as prescribed by the supervising physician.

# *Allied Health Professional Student*

## Supervising Physician Form and Scope of Practice

I hereby agree to abide by the selected Scope of Practice and Policies & Procedures of Providence Alaska Medical Center.

\_\_\_\_\_  
Signature of AHP Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
AHP Student's Name

\_\_\_\_\_  
Dates of /Rotation:

I hereby attest to the qualifications of this Student applicant. As sponsoring/supervising physician, I will assume the responsibility of seeing that the Allied Health Professional (AHP) Student will perform only those tasks which he/she is authorized to perform as authorized by the Providence Health & Services Alaska Region Board as well as those outlined in Policy AHP 800-001. I understand I have full responsibility for all actions or omissions of this Student at Providence Alaska Medical Center. I understand I am responsible for the active supervision of this Student and that my responsibilities require me to be ready to assume the care of any patient treated by him/her. Should my supervising relationship with this Student change, I understand I am responsible for all care provided by him/her until I provide written notification to the Medical Staff Office that the relationship has changed. I agree to co-sign all chart notes and orders written (within 24 hours) by a Student. I will write progress notes in the patient charts that will establish the full extent of the AHP Student involvement with the care of each patient.

\_\_\_\_\_  
Supervising Physician (*Signature*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Supervising Physician's Name (Print)

The following Active Staff Member of the Allied Health Professional Staff has consented to supervise the AHP Student in my absence or in addition to my agreed supervision:

\_\_\_\_\_  
Allied Health Professional Staff Member (*Signature*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Allied Health Professional Staff Member's Name (Print)

### Professional Liability Action Explanation Form

This form must be completed if you answered "yes" to question #1 or 3 on page 4

*Please complete this form for each pending or settled professional liability action or any payment made on behalf of applicant. All questions must be answered completely. If additional sheets are required, please photocopy this page prior to completing. Please provide us with a separate sheet for each malpractice action.*

### Please Print

Date of Alleged Incident	Date Suit Filed
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Location of Incident

Your Relationship to Patient (Attending Provider, Surgeon, Assistant Surgeon, Consultant, etc.)

Allegation

Liability Carrier when Incident Occurred

Additional Named Responsible Parties/Defendant(s)

### Claim Status

OPEN – If open, amount being sought

CLOSED – If closed, indicate method of closing                       Dismissal                       Settlement                       Judgment

Amount of settlement or judgment

*Summarize the circumstances giving rise to the action. If the action involves patient care, describe a narrative, which provides your care and treatment of the patient. If additional space is necessary, attach adequate clinical detail to allow proper evaluation by a committee of physicians. Include: 1) Condition and diagnosis at time of incident, 2) dates and description of treatment rendered and 3) condition of patient subsequent to treatment. Please print.*

### SUMMARY

I certify that the information in this document and any attached documents is true, correct and complete. I agree that Providence Health & Services – Alaska, Providence Alaska Medical Center ("PAMC) and its representatives and any individuals or entities providing information to PAMC in good faith and without malice shall not be liable for any act or omission related to the evaluation or verification contained in this document, which is part of the application which I am submitting to PAMC. I further agree to notify PAMC within 15 days of my change to the information included in this form.

Signature:	Printed Name:	Date:
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PROVIDENCE ALASKA MEDICAL CENTER MEDICAL STAFF PRACTITIONER DISCLOSURE & RELEASE (CLIENT # 5616)



Credentialing and Background Investigation

APPLICANT'S FULL NAME \_\_\_\_\_

Any Other Names Used \_\_\_\_\_

Social Security No. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date of Birth<sup>1</sup> \_\_\_\_\_

Current Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Driver's License State \_\_\_\_\_ No. \_\_\_\_\_

Please provide all locations where you have resided or practiced for the past ten (10) years, starting with your current residency.

	City	State	Dates	From:	To:
1.	_____	/ _____	_____	_____	_____
2.	_____	/ _____	_____	_____	_____
3.	_____	/ _____	_____	_____	_____
4.	_____	/ _____	_____	_____	_____
5.	_____	/ _____	_____	_____	_____
6.	_____	/ _____	_____	_____	_____
7.	_____	/ _____	_____	_____	_____
8.	_____	/ _____	_____	_____	_____

Pursuant to the requirements of the Fair Credit Reporting Act, I acknowledge that a credit report, consumer report<sup>2</sup> and/or investigative consumer report<sup>3</sup> may be made in connection with my application for employment, contract or privileges with the respective facility. I understand that these investigative background inquiries may include credit, consumer, criminal, driving, prior employment and other reports. These reports may include information as to my character, work habits performance and experience, along with reasons for termination of past employment from previous employers. Further, I understand that the respective facility and PreCheck, Inc. may be requesting information from various federal, state, and other agencies which maintain records concerning my past activities relating to my educational/school records, driving, credit, criminal, civil and other experiences, as well as claims involving me in the files of insurance companies.

I authorize, without reservation, any party or agency contacted by PreCheck, Inc. to furnish the information mentioned above. A photocopy of this authorization shall have the same effect as the original.

I understand the information obtained will be used as one basis for employment, contract or privileges or their denial. I hereby discharge, release and indemnify the respective facility, PreCheck, Inc., their agents, servants and employees, and all parties that rely on this release and/or the information obtained with this release from any and all liability and claims arising by reason of the use of this release and dissemination of information that is false and untrue if obtained from a third party without verification.

It is expressly understood that the information obtained through the use of this release will not be verified by PreCheck, Inc. The authorization granted herein shall be effective throughout the term of my employment, contract or privileges.

I have read and understood the above information, and assert that all information provided by me is true and accurate.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Upon your written request within a reasonable period of time, the investigative agency compiling a report will make a complete and accurate disclosure of the nature and scope of the investigation. In addition, if you are denied employment, contract or privileges either wholly or partly because of information contained in a consumer report, a disclosure will be made to you of the name and address of the investigative agency making such a report.

<sup>1</sup> The Age Discrimination in Employment Act of 1987 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years of age. This information is for consumer report purposes only.

<sup>2</sup> A "Consumer Report" may consist of employment records, educational verification, licensure verification, driving record, previous address and public records relative to criminal charges.

<sup>3</sup> An "Investigative Consumer Report" means a consumer report or portion thereof in which information on a consumer's character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with persons having knowledge.

## **Instructions for completing the Computer User Account Application Form**

- ❖ **Supervising physician name AND SIGNATURE** must be completed (except for physician applications) before your account can be built.
- ❖ **Physician ID #** is assigned by Medical Staff office and is the number physicians use for dictating within PAMC.
- ❖ **Office Phone Number** is needed as well as your **Office Location**, so that the IS trainers can contact you.
- ❖ **Remote Access** is needed to login to the system any time you are not on the PAMC network. Please be sure to **answer one of the questions** needed to confirm your identity when calling the Service Desk for password changes or resets.
- ❖ **ProvPort**, the replacement for Apollo, will be available starting early in **2005**. All patient information (demographics, transcription, radiology results, microbiology and pathology results) back to **January 2000** will be available in ProvPort at that time. Discrete lab results dating from **August 27, 2004** will also be available in ProvPort, but historical lab results prior to this date will need to be viewed in **Apollo**.
- ❖ Please note that physician office staff may access Apollo or ProvPort between the hours of **6 am and 7 pm Monday – Friday**. Access outside those hours (e.g. on Saturday) must be specifically requested and approved. **Physicians have 24-hour access to all applications.**
- ❖ Physician office staff requesting ProvPort access must specify whether they are a **clinical user** or **business user**. Clinical users have a ‘business need’ to see patient test results and transcription, while business users only need to see patient demographics (facesheets) and insurance information.
- ❖ Physicians may select **Synapse, ESA** as well as **Apollo/ProvPort**. PHS Contract physicians (e.g. Radiologists, Emergency Room physicians, Pathologists) may also request network access and email.
- ❖ The signed Confidentiality Statement must be returned with **all** applications.

**\*\*Please complete all fields\*\***

# Application for Computer User Account

New    Change    Delete  
 Physician/PA/ANP    Other: Medical/AHP Student

Today's Date		List any EXISTING User ID's	
First Name	Middle Initial <b>(REQUIRED)</b>	Legal Last Name	
Position Title		E-mail	
Supervising Physician's PRINTED Name and Signature:		Physician's ID number:	
Physician's Office Name:		Office Phone Number:	
Office Location:			

Please complete the security question below:

**Remote Access ([myweb.provak.org](http://myweb.provak.org)):**

For the purpose of confirming your identity for password changes, select a question below and write the answer in the blank: **(REQUIRED)**

- Mother's maiden name: \_\_\_\_\_
- Name of favorite pet: \_\_\_\_\_
- Place of birth: \_\_\_\_\_
- Last high school attended: \_\_\_\_\_

**ProvPort (patient data)**

Physician/PA/ANP

**INTERNET**

Network Access + email (PHSA Contract Physicians only)

Synapse (Digital xray images)

ESA (Electronic Signature Authentication for dictated documents)

QS

A signed confidentiality statement must be on file for account activation.  
See Data Security Policy #R840.002 (Region Policy Manual)

## MIS Use Only

<b>Application approved by:</b>	
<b>Date Created:</b>	<b>Account Created by:</b>
<input type="checkbox"/> Network User ID: <input type="checkbox"/> Lawson User ID: <input type="checkbox"/> Remote Access User Activated: <input type="checkbox"/> HPF User ID:	<input type="checkbox"/> Care Record (clinical database) User ID: <input type="checkbox"/> ProvPort User ID: <input type="checkbox"/> Synapse User ID:
<b>User notified Date:</b>	<b>Signature of account creator:</b>

## PROVIDENCE HEALTH SYSTEM CONFIDENTIALITY STATEMENT

I agree that access to confidential information within the Providence Health System is privilege. I will access and use this data only to the extent required by my responsibilities. I will not abuse access to the computer systems to examine information that is beyond my legitimate need to know.

I agree to hold as confidential all information obtained from any Providence Health System source (such as verbal, computer, or paper records) during the course of and following my association with Providence Health System.

I understand any computer accounts and associated passwords assigned to me are for my exclusive use and are to be held in confidence. I agree to not allow any other person to use the computer system under my password. I agree to notify Management and Information Services Department if I have reason to believe that any other person may know my password. I understand my computer account and password will be considered my computer signature, and I will protect it accordingly.

I will not disclose any proprietary or copyrighted information related to any computer application.

I have reviewed Providence Health System Policy R840.002 Data Security. I agree to abide by this policy. I understand that willful disclosure of mine or any other user's password to anyone other than a Management and Information Services employee constitutes misuse of a password and may be considered grounds for disciplinary action or termination.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Office Name

\_\_\_\_\_  
Date