UW Medicine

SCHOOL OF MEDICINE

Department of Obstetrics & Gynecology
BB-667 Health Sciences Building, Box 356460
Seattle, WA 98195-6460 USA
Phone (206) 543-3892/Fax:(206) 543-3915
whiatt11@u.washington.edu
http://depts.washington.edu/obgyn/clerkship

OBSTETRICS & GYNECOLOGY

University of Washington Medical Center

Dear Student:

We would like to welcome you to your Obstetrics and Gynecology Basic Clerkship. During this six-week clerkship, you will have the opportunity to apply and increase your knowledge in both clinical and didactic settings. Our faculty members enjoy teaching, especially in a one-on-one basis. We hope you will take advantage of their expertise and learn as much as possible; do not be afraid to ask questions.

A general orientation for Alaska students takes place on the first morning of the clerkship at the Anchorage Women's Clinic at the Providence Alaska Medical Center in Anchorage. Core textbooks for the rotation will be on loan to you and distributed at orientation. Your rotation schedule will be given to you during orientation at the site. You will need your black bag of instruments for clinic and your white coat.

If you have questions or problems, you may call Michelle Devine, WWAMI Assistant, at (907) 786-4747

Dates to Remember

Complete, up-to-date clerkship and schedule information is available online at:
http://depts.washington.edu/obgyn/clerkship/

1st day of Clerkship

- Orientation, 7:00am, Anchorage Women's Clinic

Last Day of Clerkship

- Final Written Exam, Anchorage or Seattle

If you have any questions, either before or during the clerkship, please do not hesitate to call us.

Vicki Mendiratta, MD
Clerkship Director
OB/GYN Division of Education
vmendira@u.washington.edu

Whitney Hiatt
Clerkship Coordinator
206-543-3892
whiatt11@u.washington.edu

INFORMATION AND GUIDELINES FOR WWAMI OB/GYN CLERKSHIP
Anchorage, Alaska

Welcome to the WWAMI OB/GYN Clerkship in Anchorage, Alaska. We hope this academic experience will be a rewarding one for you and that it will give you a good perspective on the uniqueness of our state. In order for us to be of maximum assistance to you, we are providing the following information and guidelines. It is important that you follow these guidelines so that we can handle the necessary paperwork and requirements of both the University of Washington School of Medicine (UWSoM) and the University of Alaska Anchorage (UAA).

Clerkship Participation

You will receive a separate packet with academic expectations and requirements. All academic and clinical issues are to be referred to:

Katie Ostrom, M.D.
Anchorage Women's Clinic
3260 Providence Dr., Ste. 425
Anchorage, AK 99508
Phone: (907) 563-7228
FAX: (907) 561-1304

Contacts at UAA

Dr. Dennis Valenzeno, Director	(907) 786-4789	afdpv@uaa.alaska.edu
Maryann Kniffen, Program Coordinator	(907) 786-4794	maryann@uaa.alaska.edu
Kathleen Boeckman, Administrative Assistant	(907) 786-4789	anksb1@uaa.alaska.edu

WWAMI Biomedical Program
University of Alaska Anchorage
3211 Providence Drive, Engineering Bldg. 331/333
Anchorage, AK 99508
FAX: (907) *786-4700*

Other UAA Contacts

University Police Department	*786-1120*	**Emergency: 786-4911 (UAA)**
UAA Information Technology Services {ITS}	*786-4646*	Or: **911 (Anchorage)**
University Housing, Commons Desk	*751-7202*	
WolfCard Office	*University Center, Room 109 (Old Seward Hwy & 36th Avenue)*	
Wells Fargo Sports Complex	*UAA Main Campus {Corner of Providence & Seawolf Drives)*	

Arrival in Anchorage

You should plan to arrive in Anchorage by the evening prior to your clerkship starting date. Take a cab directly to UAA Student Housing Commons Building, at 3700 Sharon Gagnon Lane (off Elmore Street, between Providence Drive and Tudor Road). **To be reimbursed for your cab fare, bring your receipt to Kathleen in the Alaska WWAMI Office.**

Go to the Commons Building main desk, and identify yourself as a WWAMI OB/Gyn medical student who will be staying in MAC 5-107 (Main Apartment Complex, Building 5, Room 107). During the fall and spring semesters, the Commons Building is open 8:00am to 12:00 pm Monday through Friday and 10:00 am to 12:00 pm Saturday/Sunday. Summer hours are 8:00am to 5:00pm Monday-Friday only. If you arrive when the Commons Building is closed, call the MAC Resident Assistant on duty at **(907) 529-9176.**

Filling Out Forms/Getting ID Cards

You will need to give Kathleen Boeckman at the UAA WWAMI office a call to arrange a time to stop by and complete the following forms:

Driver Questionnaire (and to provide a copy of your driver's license)

Vehicle Use and Housing Agreements
UAA Computer Account Application-this allows you to use the UAA internet service, computers, and library *(optional)*

These forms should be completed within the first few days after your arrival in Anchorage. You may get a UAA ID *(WolfCard)* at the WolfCard Office in the University Center. *WolfCard benefits*: use of the UAA library and campus computers; free use of the People Mover public bus system; and use of the UAA Wells Fargo Sports Complex facilities after payment of a $54.00 per-semester fee.

The Apartment

The MAC (Main Apartment Complex) 5 apartment building is across the street from North Hall. Facing the building, the laundry facilities are on the right, and the dumpster is on the left. MAC 5-107 is a 4-bedroom apartment located on the first floor, with four bedrooms labeled A, B, C, and D. Each room has an electronic keycard that opens that door to that particular bedroom and the front door. If your room keycard is not on the desk in your room when you arrive, you can have a new keycard made at the Commons Building main desk.

The apartment has one bathroom, a kitchen, and a storage area. The kitchen contains basic cookware, dishware, and small appliances (coffee pot, microwave). Meal cards are not provided; students pay for their own food and use the kitchen for preparing meals.

The bedrooms are supplied with linens, pillows, and towels. The bathroom contains basic cleaning supplies. Purchase of additional cleaning agents and paper products is the responsibility of the student. The storage area is used to store the tires for the car (winter/summer), bikes, and ski equipment. There is a television with VCR and cable service in the living room.

Phone/Voice Mail

Each bedroom has a telephone with voicemail service. If you need assistance with the voicemail system, contact the staff at the Commons building desk.

Mailbox

One mailbox is shared by all four WWAMI Clerkship apartments. The mailbox (**#M007)** is located in the entryway of the laundry room. Your mailing address is as follows:

<Your Name>
WWAMI Clerkship Student
3700 Sharon Gagnon Lane
Box M007
Anchorage, AK 99508

Make sure you include "Box M007" and the "WWAMI Clerkship Student" line, or you won't receive your mail. Do not put the apartment number on the address.

Laundry Facilities

Laundry facilities are available. If you are facing the MAC apartment building, the laundry facilities are to the right of your apartment building.

Internet

Each bedroom is equipped with a cable modem internet connection. Talk to Joe Michael at the University Housing office if you don't have a cable modem box in your room. If there is a problem with your connection, call the UAA ITS office for assistance.

Commons Building Exercise Room

The Commons Building contains an Exercise Room that residents of UAA student housing may use. It is open any time that the Commons Building is open; your room keycard will unlock the Exercise Room door.

Apartment Supplies

If the room lacks linens, contact Kathleen Boeckman at the WWAMI office.

Maintenance Problems

Call the main housing office to place a work order if you have any maintenance problems in the apartment (e.g. plumbing or heating problems or broken fixtures). *Please help us avoid costly repairs by reporting maintenance problems promptly.*

Ground Transportation

An all-wheel drive 2010 Subaru Impreza sedan (silver, license plate# FGC 706) is provided for your use. You will find the car keys on the dining room table. The UAA WWAMI Biomedical Program leases the car for the clerkship. You will need to pay for your own *gas*, as no gas card is provided. A parking permit sticker for the UAA lots and a sticker which allows you to park in the apartment/residence hall parking lots are provided and will be on the car so that you will be able to park on campus without getting a ticket. Parking permits are not required during the summer semester.

Use of the car for educational purposes takes priority, but reasonable use for personal needs is acceptable. For insurance purposes, the car may be driven only within a radius of 300 miles from Anchorage. **Personal use of the car for any trip more than a 300-mile radius from Anchorage is an exception and must be cleared ahead of time by Dennis Valenzeno, Director.** Please call the office to do this.

When you arrive, the car should be clean and filled with gas; *please leave it in the same condition for incoming students.* Any performance irregularities should be reported immediately to Maryann Kniffen or Kathleen Boeckman.

NOTE: YOU are responsible for all parking and traffic violations. Failure to pay them promptly will be reported to the Office of Academic Affairs at UWSOM.

From time to time, due to schedule conflicts, it may be necessary to use taxi cabs or buses to and from a clinical site. Only **WITH RECEIPTS,** each student may be reimbursed up to $50.00 for ground transportation. To receive reimbursement for the taxi cab ride back to the airport, you **MUST get a RECEIPT** and send it with your mailing address to:

Kathleen Boeckman
UAA WWAMI Biomedical Program
3211Providence Drive, ENGR 333
Anchorage, AK 99508

PLEASE NOTE

No pets are allowed in the WWAMI apartments.
Students who use the WWAMI apartments are expected to do their own routine cleaning (see attached check-out guidelines).
Someone from the UAA WWAMI Biomedical Program Office will inspect your apartment on the final day of your clerkship.
A cleaning charge of $50.00 per occupant will be assessed if the apartment is not clean when inspected.

At the End of the Rotation

Leave the apartment clean: this includes the bedroom, kitchen, living room, entryway, and bathroom.
Vacuum, sweep and mop the floors.
Wash all towels and linens, including mattress and pillow covers; leave clean linens folded on the bed.
Leave coffee pot, microwave, refrigerator and dishes clean. Dispose of old/perishable food.
Take out all the trash.
Leave car keys on the dining room table.
Leave the room keycard on the desk in corresponding bedroom; shut and lock the bedroom door to secure the room.

Other Clerkships in Anchorage

Chronic Care	907-458-4802	Beverly Spears/Or. Nancy Cross	MAC 5-103
*AFMR Family Medicine (*MS3)	273-9331	Brenda Zemba/Dr. Bob McAlister	MAC 5-103
*AFMR Family Medicine (*MS4)	212-6580	Jed Wade/Jan Abbott	MAC 5-103
Internal Medicine	264-1166	Dr. Norm Wilder	MAC 5-103
Neurology	206-616-6992	Goldie Pontrelli/Drs. Ellenson & Trimble	MAC 5-103
Pediatrics	562-2120	Dr. Erin McArthur	MAC 5-305
Psychiatry	269-7150	Rose Scogin/Dr. Jenny Love	MAC 5-204

We hope your 08/GYN Clerkship rotation and your stay in Anchorage will be memorable and enjoyable!

Student Name {please print)

Today's Date

Anchorage WWAMI 08/GYN Clerkship
Housing Agreement- Apartment MAC 5-107

At the End of the Rotation I Agree To:

Leave the apartment clean: this includes the bedroom, kitchen, living room, and bathroom.

Vacuum, sweep and mop the floors.

Wash all towels and linens, including mattress and pillow covers; leave clean linens folded on the bed.

Leave coffee pot, microwave, refrigerator and dishes clean. Dispose of old food.

Take out all the trash.

Leave the car keys on the dining room table.

Leave the room keycard on the desk in corresponding bedroom; close and lock the bedroom door to secure the room.

In Addition:

I understand that **NO PETS** are allowed in the WWAMI apartments.

I acknowledge that **a cleaning charge of $50.00 per occupant will be assessed** if the apartment and linens are not left clean.

Agreed:

Student Signature

Student #

Phone#

E-mail Address

Anchorage OB/GYN (OB GYN 671)
Clerkship Assignment

Dates of Rotation

Attending Physician/Supervisor

Housing Dates

NATIONAL INDEMNITY COMPANY
NATIONAL FIRE & MARINE INSURANCE COMPANY
COLUMBIA INSURANCE COMPANY

NATIONAL INDEMNITY COMPANY OF FLORIDA
NATIONAL INDEMNITY COMPANY OF MID-AMERICA
NATIONAL LIABILITY & FIRE INSURANCE COMPANY

INDIVIDUAL DRIVER QUESTIONNAIRE

Named Insured **University of Alaska Biomedical Program** Policy No. (if assigned) **71 APR251461**

DRIVER IDENTIFICATION
Name of Driver _____ Date of Birth _____
(as shown on Driver's License)

Address _____ Street _____ City _____ State _____ Zip

Driver's License #	Social Security #	State Where Licensed	Expiration Date	Type of License	No. of Years Licensed	No. of Years' Experience Driving			Length of Present Employment
						Trucks	Buses	Vehic 16 Passenger and over	

NUMBER OF ACCIDENTS AND MOVING TRAFFIC VIOLATIONS IN PAST 3 YEARS

No. of Accidents	No. of Violations	Date of Accident or Violation	Explanation

(If NONE, please specify)

DRIVING RECORD RELEASE FORM
ALASKA

I, _____ do hereby authorize the Department of Public Safety, Division of Motor Vehicles, to release my driving record to Columbia Insurance Company, Omaha, Nebraska.

Signature _____

Date of Birth _____

Drivers' License No. _____

Policy Number **71APR251461**

University of Washington School of Medicine/WWAMI
Anchorage 08/GYN Clerkship

VEHICLE USE AGREEMENT

The WWAMI 08/GYN Clerkship leases a 2010 Subaru Impreza sedan {silver, license plate # FGC 706} to be used by clerkship students during each rotation in Anchorage.

I understand that I am responsible for any parking and traffic violations issued to this vehicle during my rotation and use of this vehicle. Failure to pay them promptly will be reported to the Office of Academic Affairs at UWSOM.

The insurance deductible is $500.00. I am responsible for the $500 in case of an accident while I am driving the vehicle in which it is determined that I am at fault.

I may not drive the vehicle if I have had any accidents or moving violations during the past three years. Under these circumstances, to drive the vehicle I must pay a surcharge as determined by the insurance company.

The use of the vehicle is for transportation within Anchorage. I agree that I will not use the vehicle for personal travel greater than a 300-mile radius from Anchorage. For travel exceeding 300 miles from Anchorage, I must rent a vehicle.

At the end of my rotation, I must leave the vehicle clean inside and out and with a full tank of gas.

I have read and I understand the above conditions and agree to abide by them during my stay in Anchorage with the 0B/GYN Clerkship.

_____ _____

Name {Print) Signature

_____ _____

Current E-mail Address & Phone Number Date

Keep one copy

Return signed copy to:
Biomedical WWAMI Program
University of Alaska Anchorage
3211Providence Drive, ENGR 331
Anchorage, AK 99508

UNIVERSITY
OF ALASKA

AGREEMENT TO RELEASE ALL CLAIMS FOR INJURY OR DEATH TO ME AND TO PROTECT THE UNIVERSITY AND OTHERS FROM ANY SUCH CLAIMS WHICH MAY BE BROUGHT (AGREEMENT)

THIS SECTION TO BE COMPLETED BY UA DEPARTMENT			
Department Name:	**UAA WWAMI Biomedical Program**		
Faculty/Staff Contact Name:	**Dennis Valenzeno, Director**	Phone:	**786-4789**
Name of Course/Activity:	Anchorage WWAMI Medical Student Clerkship	Date(s):	**various**
List Activities:	Medical students' use of Alaska WWAMI Leased clerkship vehicles: visits to clinical sites as required for clerkship; personal use of car as needed.		

I, _____, being 18 years of age or older, have decided to participate in the above referenced Activity or Course. I have made this choice in recognition and appreciation that there will be known and unknown risks. dangers and hazards, which may be encountered in the above mentioned Activity or Course, which may include or result from the negligence or gross negligence (herein collectively referred to as "fault") of the University of Alaska or my fellow students. With this in mind, I DO HEREBY VOLUNTARILY ASSUME ALL RISKS, DANGERS AND HAZARDS which I may encounter during my participation in, and transportation to, from or as a part of, the Activity or Course. In addition, I declare that I intend to be financially responsible for any death or injury that may occur to me during or as a result of such participation or transportation.

Further, in consideration of being permitted to participate, I hereby agree to release the University of Alaska, its Board of Regents, officers, agents, and employees, (Released Parties) from all liability and claims of any kind, including claims for loss, expense, damages, punitive damages or attorney fees, or loss of companionship or support of family, occurring during or as a result of participation in, or transportation to from or as a part of this Activity or Course (Claims). This Release applies even if such Claims are based on the fault of Released Parties.

Further, I promise to indemnify and hold harmless the University of Alaska, and pay its costs of defense, if Claims are brought by me or anyone else against any of the Released Parties to recover money damages related to injuries or death to me. This promise applies even if the Claims are based on the negligence or gross negligence of the University or other related parties.

I understand that special personal medical and accident insurance may be available to me, upon my request at my expense, through University of Alaska managed plans or otherwise. and that any obligation to purchase insurance is entirely mine.

I have entered into this Agreement on the basis of my own information and not in reliance upon representations of the University or other Released Parties. I understand that I have the right to consult an attorney of my choice before signing. I further understand that this document contains the entire agreement and no oral or written agreements limiting or modifying the effect of the terms of this Agreement exist. I agree that if any part of this agreement is held to be invalid or unenforceable for any reason, the balance of the agreement remains valid and enforceable.

I intend that this Agreement is and will be binding on my family, estate, heirs, successors, assigns, insurers, medical providers and personal representatives.

By my signature, I represent that I have knowingly and voluntarily signed this Agreement with the intent that it be a legally binding document designed to protect the University of Alaska and other Released Parties from all Claims which could be brought by myself or anyone else on account of injury or death to me, regardless of cause or fault.

SIGNATURE: _____ DATE: _____

ADDRESS: _____

_____ TELEPHONE: _____

RB: 3-25-2008 Distribution: Original - Department Copy- Participant

STUDENT ACCIDENT INSURANCE MAY BE AVAILABLE THROUGH CAMPUS RISK MANAGEMENT
UAA: 786-1351 UAF: 474-7889 UAS: 465-6496 SW: 450-8150

UAA Computer Account Application

UAA ITS Call Center | phone 786-4646 | fax 786-4813
callcenter@uaa.alaska.edu | http://technology.uaa.alaska.edu

Complete this form to apply for a UAA computer account that provides access to email and open-access computer tabs

Section 1 – Campus (choose one)

□ Anchorage (A) □Kenai Peninsula (i) □ Mat-Su (P) □ Prince William Sound (V) □Kodiak (D)
□ Chugiak-Eagle Rv (A) □ Kachemak Bay (i) □ Copper Basin (V)
□ Cordova Extension (V)

Section 2 – Account Type (choose one)

Individual Account □ Staff (N) □ Faculty (F) □ WWAMI (P) □ Patron (P)
Group/Dept. Account □ Department (Y) □Academic Class (A) □ University Club (B) □ Research (O)

Section 3 – Account Owner Information (please print)

First Name _____ M.I.___ Last Name _____
SSN or University ID #_____ Telephone & Fax #_____
Mailing Address_____
Department (F N A or Y types only) _____
Contact Email address (if preferred method of notification _____

Section 4 – Statement of Responsibility:

Access to computing systems facilities and equipment is granted to members of the University community for the conduct of University business and instruction with the understanding that such access is a privilege and carries with it certain responsibilities. Access is revoked upon termination of employment or student status. Research data or work done in the course of employment remains with the University unless otherwise noted by BOR Policy & Regulation 03.06 – Information Technology. Use of the facilities to interfere with the privacy or security of other users, for political purposes, for personal financial gain, or use that is in violation of current UAA or IT computing policies is prohibited and may result in the loss of computing privileges. Usernames are to be used only by the individual to whom it has been assigned. Usernames may not be borrowed, loaned, bought or sold. The University reserves the right to disclose the identity for a user to appropriate authorities in the course of a bona fide investigation of alleged misuse. Please read the posted *Rules of the Lab* signs at each lab. Individuals who use the lab facilities are responsible for knowing and adhering to the policies and posted rules of each lab. Further information on policies and procedures governing computer access and system resource allocations is available through consultants or your local computer coordinator. Please obtain and read a copy of the *UAA Policy on Appropriate Use of Computing Resources* document. Your signature below indicates you agree to abide by these provisions. **Must be 18 or older to sign. Minors (individuals under ager 18)must still sign this form *and* have their Sponsoring Parent fill out the *Under-Age Student Supplemental Form* in addition to this form (see reverse).**

I have read the above and agree to abide by its provisions. I understand that a violation of the provisions stated in the policy may cause suspension or revocation of network access and related privileges, and could lead to disciplinary action as specified in the UAA Student Handbook.

Account Owner Signature_____ Date_____

Information Technology use only

Assigned Username	Received By (initial and date)	Processed by (initial and date)

PROVIDENCE
Alaska
Medical Center

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.

1. **All information must be TYPED or CLEARLY HANDWRITTEN.** *(Applications that are not legible will be returned)*
2. **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)*
3. 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.
4. **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 1,000,000/3,000,000 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 ‰ Male ‰ Female
Current Year of Training 1 2 3 4 (please circle one)	Student Specialty ‰ Medical Student ‰ ANP ‰ Nurse Midwife ‰ Physician Assistant		Clinical Specialty During Rotation
Dates of Clinical Rotation 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	Cell Phone 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) ‰ Married ‰ Divorced ‰ Widowed ‰ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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? ☐ Yes ☐ 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 or Professional School Training:

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 healthcare institutions/entities where you have had and/or have an affiliation within the past ten-(10) years. Indicate affiliation status. Begin with most current 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: N/A *(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 most current and list 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: N/A *(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 1,000,000/3,000,000 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"?	☐ Yes ☐ No ☐ 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?	☐ Yes ☐ No ☐ 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?	☐ Yes ☐ No ☐ Pending
4) Has your professional liability insurance coverage ever been terminated by action of the insurance company?	☐ Yes ☐ No ☐ Pending
5) Have you ever been denied professional liability insurance coverage?	☐ Yes ☐ No ☐ Pending
6) Has any professional liability insurance carrier ever excluded any specific procedures from your coverage?	☐ Yes ☐ No ☐ Pending
7) Has any insurance company ever imposed a surcharge or additional premium because of your claims history?	☐ Yes ☐ No ☐ 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 authorized during clinical rotation(s)?	☐ Yes ☐ No
Are your Immunization Records Current to include Non-reactive TB test (0 mm PPD) or medical clearance ***(must be current within past 12 months)***?	☐ Yes ☐ 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 and an investigation or is done while the licensee/registrant/certificant is under investigation related to professional conduct:

Licensure in any state?	‰Yes ‰No ‰Pending
Disciplinary action or investigation by a state/county/province, etc. licensing board/authority	‰Yes ‰No ‰Pending
Other professional registration and/or license?	‰Yes ‰No ‰Pending
Authorization to practice in any jurisdiction (state, county, borough, parish, etc.)	‰Yes ‰No ‰Pending
DEA/Controlled Substance Registration (Federal and/or State)?	‰Yes ‰No ‰Pending
Membership or renewal of membership in any hospital medical staff?	‰Yes ‰No ‰Pending
Have you ever been the subject of an informal or formal hearing process at any hospital?	‰Yes ‰No ‰Pending
Clinical Privileges at any hospital or healthcare institution?	‰Yes ‰No ‰Pending
Request for any specific Clinical Privileges (aside from ordinary and initial requirements of proctoring)?	‰Yes ‰No ‰Pending
Board Certification?	‰Yes ‰No ‰Pending
Employment?	‰Yes ‰No ‰Pending
Any other type of professional sanction?	‰Yes ‰No ‰Pending
Participation in any managed care program, IPA, PPO, PHO, MSO, HMO, etc.	‰Yes ‰No ‰Pending
Participation in Medicare/Medicaid program, CLIA or any other health plan?	‰Yes ‰No ‰Pending
Research under any Federal or private grants?	‰Yes ‰No ‰Pending
Academic Appointment or Professional Society?	‰Yes ‰No ‰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?	‰Yes ‰No ‰Pending
Have you ever been charged with a felony that did not result in acquittal or dismissal?	‰Yes ‰No ‰Pending
Have you ever been charged with a misdemeanor that did not result in acquittal or dismissal (other than minor traffic violations)?	‰Yes ‰No ‰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?	‰Yes ‰No ‰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.)	‰Yes ‰No ‰Pending
Have you ever been adjudicated or declared incompetent?	‰Yes ‰No ‰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?	‰Yes ‰No ‰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?	‰Yes ‰No ‰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?	‰Yes ‰No ‰Pending
Have you ever been asked to surrender your license to practice any form of healthcare in any state?	‰Yes ‰No ‰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?	‰Yes ‰No ‰Pending
Does your name appear on a centralized abuse registry in Alaska or any other state?	‰Yes ‰No ‰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). 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:

(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 identify 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.

Signature:	Printed Name:	Date:

(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: ***(Must be a member of the ACTIVE Medical Staff at PAMC)***
Dates of Clinical 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.

‰	**1st & 2nd Year Medical Students**	**Scope of Practice**
	These students shall have no independent privileges. They may see patients only under the supervision of the supervising physician. They may scrub in to observe their supervising physician during obstetrical and surgical procedures, after assuring consent has been obtained from the patient.	
	These students may interview patients with their permission to write-up history and physicals; however, this information will not be entered directly into the patient's chart.	
	These students may be allowed to participate in other interactions as approved by the patient and based on the discretion of the supervising physician.	
‰	**3rd & 4th Year Medical Students**	**Scope of Practice**
	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 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

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 (Ϙ) appropriate 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 Clinical 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, simple hemostasis, 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

‰ **Surgical Assistant (SA) Student**

An actively participating SA Student is authorized to:

a.) Assist during surgical procedures **only under the direct supervision** of his/her supervising physician, a member of the Active Staff, to include, handling tissue, site exposure, using instruments, suturing, and safely positioning the surgical patient.

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) _____

PROVIDENCE
Alaska
Medical Center

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.

P l e a s e P r i n t

Date of Alleged Incident	Date Suit Filed
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

O OPEN – If open, amount being sought

O CLOSED – If closed, indicate method of closing O Dismissal O Settlement O 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:

PROVIDENCE
Alaska
Medical Center

Additional Sheet (Use and return only if needed)

Section being referenced: _____ **Explanation:** _____

Section being referenced: _____ **Explanation:** _____

Section being referenced: _____ **Explanation:** _____

Section being referenced: _____ **Explanation:** _____

Section being referenced: _____ **Explanation:** _____

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[1] _____

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[2] and/or investigative consumer report[3] 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.

[1] 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.

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

[3] 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.

800.999.9861
713.861.5959
info@precheck.com
www.precheck.com

EpicCare Link Security Individual Access Request Form
[This is for an individual/employee of a clinic to request access]

User Agreement

This form must be completed by each individual user. Each individual user must register to receive his/her own password. Passwords cannot be shared.

☐ **New** ☐ **Change** ☐ **Delete**

☐ **Physician** ☐ **Physician Staff** ☐ **Other** _____

Individual User Access Information

First Name:	Middle Initial:	Last Name:	List any Existing User ID's:

Practice Name:	Practice Street Address:	
City:	State:	Zip:
E-mail Address:	Position Title:	
Credentials:	DEA Number:	
Specialty:	Office Phone Number:	
Supervising Physician's PRINTED Name and Signature:	Physicians ID Number (Providence):	

User Security Question:
***Select a password reset question by checking the box below.**
*** Answer to password reset question.**

⋯ What is your favorite pet's name?	⋯ What is your favorite color?	
⋯ What is your mother's maiden name?	⋯ What is your date of birth?	
⋯ In what city where you born?	⋯ What is your favorite restaurant?	
⋯ In what year did you graduate high school?	⋯ What is your favorite animal?	
⋯ What was your highschool mascot?	⋯ What is your favorite book?	
⋯ What is the name of your favorite sport?	⋯ What is your favorite candy bar?	

Please check all items required:

☐ **Remote Access (myweb.provak.org):**

****Remote Access for Physician Office Staff access is limited to 6 a.m. – 7 p.m. Monday – Friday. Any additional hours must be approved. Please detail request on following lines:**

_____

_____

☐ **Epic Hyperspace (patient data)** ☐ **EpicCare Link / ProvPort (patient data)** ☐ **Physician/PA/ANP** ☐ **Nurse** ☐ **Front Desk** ☐ **Biller / Coder** ☐ **Site Administrator** ☐ **Other**	☐ **Network Access + email (PHSA Contract Physicians only)**
User Signature:	
The information I have filled out above is correct and I have signed the User Agreement : _____ _____ _____ Print User's Name User's Signature Date	
Authorized Agent's Signature:	
I agree that the above named employee(s) has my authorization to access EpicCare Link Data. _____ _____ _____ Print Authorized Agent's Name Authorized Agent's Signature Date	
Internal Use Only:	
_____ _____ _____ Date Request Received Received By Date Activation Sent to User	
Application Approved by:	
Date Created:	Account Created by:
☐ **Network User ID:** ☐ **Remote Access User Activated:** ☐ **Epic User ID:**	☐ **Care Record (clinical database) User ID:** ☐ **ProvPort User ID:** ☐ **Synapse User ID:**

Exhibit B
Terms & Conditions of Use

The protection of health and other confidential information is a right protected by law and enforced by fines and criminal penalties as well as policy. Safeguarding protected health information is a fundamental obligation for all persons accessing it. Signing below will commit you to that obligation, and WILL be used as proof that you understand and agree to the stated basic duties and facts regarding privacy.

Signing this form indicates the following:

1. ____ I agree to protect the privacy and security of confidential information I access through Providence's electronic records at all times.

2. ____ I agree to a) access confidential information to the minimum extent necessary for my assigned duties and b) disclose such information only to persons authorized to receive it.

3. ____ I understand the following:

a. ____PROVIDENCE HEALTH & SERVICES ALASKA ("Providence") tracks all user IDs used to access electronic records. Those IDs enable discovery of inappropriate access to patient records.

b. ____ Inappropriate access and/or unauthorized release of confidential or protected information will result in disciplinary action, up to and including termination of employment, and will result in a report to authorities charged with professional licensing, enforcement of privacy laws and prosecution of criminal acts. I further understand and agree that inappropriate access and/or unauthorized release of confidential or protected information may result in temporary and/or permanent termination of my access to Providence electronic records.

c. ____ That I will be assigned a User ID & a one-time use activation code. I agree to immediately select and enter a new password known only to me. I understand I may change my password at any time, and will do so based on Providence established policy and/or when prompted. I understand that I am to be the only individual using and in possession of my confidential password. I am aware that the User ID and password are equivalent to my signature. Also, I am aware that I am responsible for any use of the system when accessed utilizing my User ID and password. This includes data entered, viewed, printed or otherwise manipulated. If I have reason to believe that my password has been compromised I will report this information to Providence and I will also immediately change my password. I understand that User IDs cannot be shared. Inappropriate use of my ID (**whether by me or anyone else**) is **my** responsibility and exposes me to severe consequences.

4. ____ I understand that confidential health information includes but is not limited to: Any individually identifiable information in possession of or derived from a provider of health care regarding a patient's medical history, mental or physical condition or treatment, as well as the patient's and/or his/her family member's records, test results, conversations, research records and financial information. (Note: this information is defined in the Privacy Rule as "protected health information.") Examples include, but are not limited to:

- Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;
- Patient insurance and billing records;
- Centralized and/or department based computerized patient data and alphanumeric radio pager messages;

5. ____ I understand confidential employee business information that is not available in the public domain includes but is not limited to:

- Employee home telephone number and address;
- Spouse or other relative names;
- Social Security number or income tax withholding records;
- Information related to evaluation of performance;
- Other such information obtained from Providence's records, which if disclosed, would constitute an unwarranted invasion of privacy; or disclosure of protected or confidential information that would cause harm to Providence.

Signature: _____

Print Name: _____

Date: _____