GRADUATE MEDICAL EDUCATION PROGRAM REQUIREMENTS
Residents

In preparation for completing this Clinical Rotation Request, learners must review the following documents available on our Providence Clinical Educational Rotations website:

- Compliance Packet
- HIPPA
- Providence Code of Conduct

After review of the documents, complete all information requested in this form, making sure all signatures, initials, and dates are filled in. Take note of what is to be included in the 'complete packet' and send as one email. We request a lead time of **4 weeks** to process the application due to school affiliation requirements.

In an effort to reduce paperwork, Providence Health & Services will accept the signed Program Attestation (page 3) from your program/school in lieu of documentation noted. Please note that COVID and annual influenza vaccinations are required unless you have a signed Providence declination form on file with your school. Providence reserves the right to require the documentation, if deemed necessary, and you must produce it within 1 day of the request.

Complete Clinical Rotation Request Packet

Working with your program coordinator, submit to the appropriate Providence Program Coordinator**:**

1) Clinical Rotation Request packet;
2) Digital Photo (head shot with plain background);
3) HR Student Affiliation spreadsheet.

You will receive an approval notification from the program office and you cannot start your clinical rotation until you receive this notification.

PROVIDENCE Health & Services

Clinical Rotation Request
Residents

Print or type all information. *A detailed explanation of requirements is included in the Compliance Packet available online. Please complete all forms and submit 4 weeks prior to the beginning of the rotation. Accuracy, timeliness and completeness are the keys to avoiding delays in this process.*

Name: (Last)_____ (First)_____ (MI)_____ Suffix: _____

Gender: M☐ F☐ Other ☐ Date of Birth _____ (mm/dd/yyyy) SSN* _____

Home Address: _____ City/State/Zip _____

Email Address: _____ Telephone: _____

Program/School Name: _____ Program Coordinator Name: _____
Program Coordinator email: _____

U.S. Citizenship: Yes ☐ No☐ If no, please indicate current visa status _____

For Residents:

NPI _____ Oregon Medical/Dental/Nursing License _____ DEA (if applicable) _____

Current Degree: ☐ DO ☐ DDS ☐ DMD ☐ DPM ☐ MD ☐ MD, DDS ☐ MD, DMD ☐ MBBS

Name of Medical School graduated from_____ Date of Graduation _____

If FMG; ECFMG number _____ ECFMG Certificate date_____

Dates of Rotation _____ (mm/dd/yyyy) **to** _____ (mm/dd/yyyy) Residency year ___

Preceptor Full Name: _____

Rotation Specialty: _____

Have you had previous Epic Training? ☐ Yes ☐ No

Have you had previous access to Providence electronic systems? ☐ Yes ☐ No

Indicate below any Providence facilities where you will be during this rotation. If you will be at more than one facility, please indicate where you will be **starting**. _____

☐ Providence Hood River Memorial Hospital
☐ Providence Medford Medical Center
☐ Providence Milwaukie Hospital
☐ Providence Newberg Medical Center
☐ Providence Cancer Center
☐ Providence Portland Medical Center
☐ Providence St. Vincent Medical Center
☐ Providence Willamette Falls Medical Center
☐ Providence Seaside Hospital
☐ Providence Outpatient Clinic _____

**Social Security Number (SSN) is required.*

Program Attestation of Applicant Status

I attest the applicant, _____, for training:
Printed Name of Applicant

1.	Is in good standing, qualified to do a clinical rotation, and not on remediation or probation in their training/education program.	Yes ☐ No ☐
2.	Is covered by professional liability insurance, valid in the State of Oregon, for the duration of each placement, as determined in school affiliation agreement on file.	Yes ☐ No ☐
3.	Has major medical insurance coverage, valid in the State of Oregon that will be in effect during the requested rotation.	Yes ☐ No ☐
4.	Has completed TB exposure screening, annual influenza vaccination, Measles, Mumps, Rubella (MMR) and Varicella immunizations, and Hepatitis B vaccination, Covid-19 vaccination, and Tetanus, Diphtheria, Pertussis (Tdap) vaccine.	Yes ☐ No ☐
5.	Has passed a criminal background check, which includes SSN trace and queries of state and national criminal background history, screen of OIG List of Excluded Individuals and Entities (LEIE) sanctions list and Government Services Agency (GSA) Excluded Parties List System (EPLS), and sex offender registry list.	Yes ☐ No ☐
6.	Has documented proof of 10-panel drug screen, which is inclusive of the following eight substances: Amphetamines, including methamphetamines; Barbiturates, Benzodiazepines, Cocaine, Marijuana, Methadone, Opiates, Phencyclidine.	Yes ☐ No ☐
7.	Has a current BLS or ACLS certification for healthcare providers per the American Heart Association standard.	Yes ☐ No ☐
8.	The trainee has documented proof of Bloodborne Pathogen training (OHSA) and familiarity with OSHA-recommended safety guidelines (including fire and electrical safety; personal protective equipment; hazard communications; and infection prevention practices).	Yes ☐ No ☐
9.	The resident has an appropriate Oregon Medical or Dental license.	Yes ☐ No ☐
10.	The resident is a U.S. citizen or has a valid visa to work in the United States.	Yes ☐ No ☐
11.	Goals and objectives, rotation length, and supervision expectations of this clinical rotation have been provided in writing to the Providence site director and supervising member. This includes a Program Letter of Agreement if required by the program accrediting body.	Yes ☐ No ☐

_____ _____
Signature of Program Representative Program/Institution/School Name

_____ _____
Printed Name of Program Representative Date (mm/dd/yyyy)

***** *This form is used in lieu of school or program attestation letter and in lieu of providing documentation for learner's background check, drug screen, immunization records and BLS/ACLS certifications. However, Providence reserves the right to ask for documents for inspection.*

Applicant Behavior, Conduct and Performance Expectations

I shall maintain current licensure, board certification (where appropriate), adequate experience, continuing education and training to maintain proficiency in the area(s) of specialization (current professional competency); utilize good judgment as to my capabilities and limitations; and be of adequate physical and mental health status, to the satisfaction of the Community Ministry Boards. Further I shall maintain and provide documentation of the above, on request, qualifying that I am professionally competent and the patients I treat can reasonably expect to receive quality medical care (as appropriate).

I shall clean my hands with alcohol hand rub or soap and water before and after every patient contact to protect patients from hospital acquired infections. I shall abide by all State and Federal laws and regulations and shall abide by the ethical principles of state and national professional associations and societies appropriate to my professional education and licensure. I will work cooperatively, collaboratively and constructively with other health care member and with the health system and hospital employees to maximize the quality of patient care and to avoid disruption of the patient care and operation of the hospital. This included but is not limited to the following professional expectations:

- Treat all patients, families, Members and health system employees with respect, courtesy, and dignity, in language and nonverbal behavior.
- Provide information to patients about their care to ensure informed decision-making, including a documented informed consent discussion.
- Participate actively and constructively in established processes to avoid potential harm to patients including surgical and invasive procedure verification (patient, procedure, site), and in resolving system problems that have the potential to harm patients.
- Maintain confidentiality in all health care matters.
- Assure that all interactions with health system employees are free of hostility; verbal mental and/or physician harassment, intimidation, sexually suggestive or explicit behavior, retribution implied or explicit on campus or in the community, behavior that is profane, vulgar, or demeaning toward others, violations of reasonable personal space,
- Assure that conflict, described in objective behavioral terms, is resolved in a professional, constructive manner, through established mechanisms, and in a confidential manner when performance or competence issues arise, refraining from derogatory or demeaning comments to others,
- Conduct care in a way consistent with the faith tradition of Providence Health & Services, as expressed in such places as the Ethical and Religious Directives for Catholic Health Services, and to make use of the ethical resources available, such as the ethics consultation team at the specific facility or the Providence Center for Health Care Ethics when there are questions regarding these directives or general ethical principles.

_____ _____

Applicant's Printed Full Name Date (mm/dd/yyyy)

_____

Applicant's Signature

Applicant Attestation

I attest that I have read the required documents on the Providence Clinical Educational Rotations website:

☐ HIPPA

☐ Code of Conduct

_____ _____

Applicant's Printed Full Name Date (mm/dd/yyyy)

_____

Applicant's Signature

Providence Non-Employee Behavioral Standards & Privacy Attestation

Behavior

- All Providence clinical opportunities are a privilege. It is expected that students performing clinical at a Providence facility will conduct themselves in the behavior and decorum expected of a clinical professional.
- Students are expected to fully participate in learning activities and demonstrate active listening skills, eye contact, a positive attitude and positive non-verbal communications. Students are to eagerly engage in dialogue with staff and to be accepting and encouraging of other students as they learn.
- Any Providence employee may remove the student from the clinical environment if it is suspected that the student is under the influence of drugs or alcohol, the care provided by the student is assessed as unsafe for the patient, or if the student is unprepared for the clinical experience.

Respectful Treatment

- Providence facilities are places of business and faculty and students are expected to exhibit a professional demeanor and appearance at all times.
- Students and faculty will adhere to providence facility dress code and policies and wear appropriate ID badge(s) any time they are at the facility for clinical related activities.
- All Providence staff, vendors, contract personnel, volunteers, school personnel, students, patients, their families and visitors shall be treated in a respectful dignified manner at all times. Language, non-verbal behavior gestures, attitudes and activities shall reflect this respect and dignity of the individual at all times.

Drugs and Illegal substances

- Regardless of the legality of a drug, Providence is a drug free environment. Students and faculty are expected to abstain from the personal use of drugs while performing clinical at any Providence facility.

Photography, Cell phones/electronic devices, and Social Media

- Cell phones are not allowed in any clinical procedural area (OR, endoscopy, catheter lab, etc.). Please leave them at home, in your car, or in a locker in the scrub change area.
- Students may bring cell phones to non-procedural areas, but they should only be used for emergency communication (e.g. sick child) and clinical purposes (e.g. looking up a treatment, medication or communicating with clinical instructor). Students should limit non-clinical related phone use (text messages, checking for voice messages, email, etc.) to breaks.

Photography of patient, body part, staff, or clinical environment is absolutely prohibited and is grounds for removal from clinical at any Providence facility indefinitely and may result in legal action by the patient or Providence.

- The student may not share any information about patients, staff, clinical environment or learning experience via any social media venue. Doing so is grounds for removal from clinical at Providence indefinitely and may result in legal action by the patient or Providence.
- No student is to use an iPod or other music and/or video device, cell phones, laptops or other computed devices, do homework or otherwise veer from the learning experience unless on a break or the device is used to enhance the clinical activity.

_____ _____

Applicant's Printed Full Name Date (mm/dd/yyyy)

_____

Applicant's Signature

Providence Non-Employee Confidentiality and Non-Disclosure Attestation

- I understand that in the course of performing services on behalf of Providence Health System – Oregon (PHS-OR), I will have access to information not generally available or known to the public. I agree that such information is confidential information that belongs to PHS-OR. Confidential information includes but is not limited to patient, customer, member, provider, group, physician, employee, financial and proprietary information, whether oral or recoded in any form or medium. I agree that information developed by me, alone or with others, may also be considered confidential information belonging to PHS – OR.

- I will hold confidential information in strict confidence and will not disclose or use it except:

  (1) as authorized by PHS-OR;
  (2) as permitted under written Agreement between PHS-OR and my employer or myself;
  (3) consistent with the scope of services I perform on behalf of PHS- OR and with applicable PHS-OR policies and practices;
  (4) solely for the benefit of PHS-OR, its patients, members and other customers;
  (5) as required by applicable law.

- I understand that this Confidentiality and Nondisclosure Statement does not limit my right to use my own general knowledge and experience, whether or not gained while contracting with PHS-OR, or my right to use information if this is or becomes generally known to the public through no fault of my own.

- I will not access confidential information for which I have no legitimate need to know.

- I understand my responsibility to become familiar with and abide by applicable PHS-OR policies and protocols regarding the confidentiality and security of confidential information.

- I understand that PHS-OR electronic communication technologies are intended for benefit of PHS-OR, however limited personal use is permitted. Personal use is defined as incidental and occasional use of electronic communications technologies for personal activities that should normally be conducted during personal time and is not in conflict with PHS-OR business requirements. Internet usage is monitored and audited on a regular basis by PHS-OR management. PHS-OR management also reserves the right to monitor e-mail and telephone usage.

- I understand that if I breach the terms of this confidentiality and nondisclosure statement or applicable PHS-OR confidentiality, privacy and/or security policies, PHS-OR may terminate my association with PHS-OR, including any written Agreements with PHS-OR. Further, PHS-OR will be entitled to all remedies it may have under written Agreement or at law, as well as to seek and obtain injunctive and other equitable relief.

- I have reviewed, understand, and agree to comply with the student behavior standards.

_____ _____

Applicant's Printed Full Name Date (mm/dd/yyyy)

_____

Applicant's Signature

Data Access Acceptable Use Agreement for Non-Providence Workforce Members

Providence Health & Services ("Providence") requires that everyone granted access to our information systems will protect our patients' information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules and other applicable state and federal laws.

I acknowledge that (*please initial*)**:**

_____ Providence is granting me access to systems and information owned or operated by Providence or one of its subsidiaries, and I will have access to confidential information not generally available or known to the public, including protected health information (PHI).

_____ Providence will issue me a unique user ID and password. I agree that I am not permitted to share this user ID or password with anyone. I will never share my password or leave it written down for others to find, nor will I utilize user ID and password auto save functionality on any computer or mobile device.

_____ I agree to immediately notify Providence by calling the Breach Reporting Hotline **866-406-1290**, if I have a reason to believe that any other person may know my user password.

_____ I understand my computer account and password will be considered my computer signature, and I will protect it accordingly. I will keep PHI out of sight and secure it when not in use to prevent unauthorized access.

_____ Federal and state laws protect Providence information to which I will have access, and I will abide by those laws. I understand what qualifies as PHI and that I am required to comply with the HIPAA Privacy and Security Rules.

_____ I agree that I will not access Providence information for which I have no legitimate need. I will not access my own records or records of my family members. I will only access minimum necessary information for which I have a legitimate reason. I understand all activity is tracked based on my user ID.

_____ I agree that I will hold Providence information in strict confidence and will not disclose or use it except (1) as authorized by Providence; (2) as permitted under written agreement between Providence and the Organization named below or myself; (3) consistent with the reasons for my access; (4) solely for the benefit of Providence, its patients, its members, or its other customers; or (5) as required by applicable law.

_____ If I am a member of a Providence medical staff, I understand I may be given access to certain tools as an important part of the delivery of medical services to Providence patients and I will use the tools to benefit Providence patients while engaged in activities that benefit Providence or its patients. I understand that the continuing medical education (CME) I may redeem from these tools is provided to me as a medical staff incidental benefit. I indemnify Providence for any liability if this benefit is not compliant with applicable law.

_____ I understand that e-mail is not a secure, confidential method of communication. I will not include confidential patient information in e-mail communications, unless using an approved secure email method.

_____ I understand that should I need to use Providence network, email, or telephone, it is a privilege that may be revoked if I misuse these services. I also understand that these services may be monitored and audited by Providence.

_____ I understand that should I need to work with Providence data outside of the systems to which I am granted access, I will use secure methods to dispose of files or documents containing PHI or other confidential information.

_____ I understand that if I breach the terms of this agreement, applicable Providence privacy and/or security policies, or applicable law (including without limitation the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH), Providence may terminate my access, and Providence will be entitled to all remedies it may have under written agreement or under applicable laws, as well as to seek and obtain injunctive and other equitable relief, or contact law enforcement.

_____ I will report all suspected privacy and security incidents immediately, but no more than 5 days from the date of discovery, to Providence's toll free **Breach Reporting Hotline number at 866-406-1290**.

I acknowledge that I have read and understand the Providence Non-Employee Data Access Acceptable Use Agreement.

_____ _____

Applicant's Printed Full Name Date (mm/dd/yyyy)

_____

Applicant's Signature

CLINICAL ROTATION REQUEST FORM: Residents from non PHSOR sponsored programs

Indicate all Providence facilities where you will be on clinical rotation:

- ☐ Providence Hood River Memorial Hospital
- ☐ Providence Medford Medical Center
- ☐ Providence Milwaukie Hospital
- ☐ Providence Newberg Medical Center
- ☐ Providence Portland Medical Center
- ☐ Providence St. Vincent Medical Center
- ☐ Providence Willamette Falls Medical Center
- ☐ Providence Seaside Hospital

Requirements

Residents from accredited residencies in medicine, podiatry, and oral-maxillofacial surgery or other health professional training programs not sponsored by PHSOR may participate in patient care in the Hospital with a supervising Member with clinical privileges. Interns are residents in their first year of training and treated the same as residents.

1. Must provide documentation of successfully obtaining MD, DO, DPM, DDS/DMD degree, or other degree deemed acceptable by the Providence Regional GME Office appropriate to their training background.
2. Must hold a valid, current license in their area of training issued by the State of Oregon, such as the Oregon Medical Board or Dental Board.
3. Must undergo other appropriate background checks, training, and verification as a learner in good standing as specified in the affiliation agreement with the training program.
4. Non-PHSOR Residents may not become privileged members of the professional staff. Prior to being enrolled in a training rotation, non-PHSOR residents must ensure an affiliation agreement between their PHSOR and their training program exists. They must also ensure a program letter of agreement (for ACGME programs) or other documentation (for non-ACGME programs is provided if not specified in the affiliation agreement which:
   a. Identifies the PHSOR clinical faculty accepting responsibility for teaching, supervision, and formal evaluation.
   b. Specifies the duration and content of the educational experience
5. Provides the policies and procedures from the training program that will govern resident education during the assignment to PHSOR, particularly resident supervision

Request	**Residents from non PHSOR sponsored programs: Guidelines for Participation in Patient Care**	Approved
☐	• May only work under the supervision of a Member with clinical privileges in accordance with accreditation guidelines and training program requirements. • May perform and record the History and Physical, progress notes, and discharge summaries with co-signature of Member. Documentation also requires an appropriate attestation statement if mandated by applicable CMS documentation regulations. • May write patient care orders without requirement for co-signature. • May perform procedures or portions of procedures under the supervision and with the permission of a Member. The supervision may be direct supervision, indirect supervision or oversight in accordance with the supervision guidelines of the training program and the learner's prior procedural experience. • May assist at surgery but may not be the primary surgeon in procedures requiring anesthesia services. • May participate in call coverage with a supervising Member in accordance with accreditation requirements but may not be the primary provider responsible for call duties. • May not be the attending practitioner of record. • Must make patients aware of, and consent to, resident involvement in their care. • Must wear Providence name badge at all times.	☐

I hereby certify that I have met the above criteria and provided the requested documentation to support the approved clinical rotation. I know of no health condition that with reasonable accommodation would impair my ability to competently perform the approved patient care activity.

_____ _____

Applicant's Printed Full Name Date (mm/dd/yyyy)

_____

Applicant's Signature