

Welcome to Children's

**WE ARE PLEASED YOU ARE JOINING CHILDREN'S
NATIONAL MEDICAL CENTER FOR PART OF YOUR
MEDICAL TRAINING!**

**THIS PACKET INCLUDES A WEALTH OF INFORMATION
TO INTRODUCE YOU TO CNMC. SEVERAL FORMS
REQUIRE YOUR COMPLETION AND SIGNATURE. WE
APPRECIATE YOUR COOPERATION IN RETURNING THE
NECESSARY PAPERWORK TO OUR MEDICAL STAFF
OFFICE ONE MONTH BEFORE YOU ARRIVE, TO MAKE
YOUR FIRST DAYS AT CHILDREN'S PRODUCTIVE ONES!**

INFORMATION MAY BE RETURNED BY MAIL TO:

MEDICAL STAFF OFFICE - CNMC

ATTN: YOLANDA JONES

12211 Plum Orchard Drive, Suite 310

Silver Spring, MD 20904

OR BY FAX TO: (301) 572-1312

**FEEL FREE TO CALL YOLANDA JONES WITH ANY
QUESTIONS:**

(301) 572-1322



ROTATING TRAINEES REQUIREMENTS FORM

- Registration Form
- Evidence of Current Medical License (*if received*)
- District of Columbia Post Graduate Physician Trainee certificate (*not applicable for NIH and Military Institutions*)
- Current Curriculum Vitae
- USMLE Step 1 and 2 scores. Provide Step 3 score, if examination was completed (*Not required if a Medical License is submitted*)
- ECFMG certificate (*if applicable*)
- Evidence of MMR, by shot or titer.
- Evidence of PPD (*within the last 12 months*) and chest x-ray for positive tests
- Annual Physical Exam (*within one year of the rotation*)
- Signed Confidentiality Statement
- Parking Form filled out (Sections 1, 2, 4 and 5)
- Sign The Orientation Brochure Acknowledgement (Stating that you have received and read the Rotating Trainee Orientation Brochure)

The following web-based courses will require a username and password which will be emailed to you when the registration form is received.

- Blood borne pathogens (OSHA)
- Safety Compliance Quiz
- CTI ___ Inpatient ___ Outpatient

*****FOR OFFICE USE ONLY*****

ENTERED INTO CHEX: _____
 ENTERED INTO STAR/PPM DATE: _____
 PHYSICIAN NUMBER: _____
 ENTERED INTO SPREADSHEET: _____
 ENTERED INTO E-WORKS: _____
 SENT TO MEDICAL RECORDS: _____
 SENT EMAIL: _____
 PROCESS COMPLETED ON: _____



MEDICAL STAFF OFFICE REGISTRATION FORM FOR TRAINEES ON ROTATION

Please complete in ink or type

Rotation in (Department Name): _____

Inclusive Dates (month/day/year): from _____ through _____

Frequency of time at Children's during the above mentioned dates
(please check one and be specific, i.e. 1/2 day per week, etc.)

_____ Daily

_____ Day(s) per week

_____ Day(s) per month

Department Contact Name: _____ Number: _____

Name: _____

First

Middle

Last

Date of Birth: _____ Social Security #: _____

Address: _____

Street

Apartment #

(____)

City State Zip Telephone Number

Email address: _____ Pager #: _____

Emergency Contact (name and telephone number): _____

Your affiliating institution's name and state: _____

Training program to which you belong at that institution: _____

The full name of medical/dental school you attend (please avoid abbreviations), city and state:

Date: DDS/ DMD/ DO/ DPM/ MD (circle one) received (month/year) _____

Your initial field of residency (ex. Anesthesiology, Pediatric Surgery, Radiology, etc.): _____

Number of prior post-graduate training years (as resident or fellow): _____

Was one of your post-graduate years of study spent in generalized study or in a transitional program? (please circle): yes no not applicable

National Boards taken? (please circle) Yes No Licensed? (please circle) Yes No

If licensed, list state(s): _____

1. Are you a physician or dental trainee (resident or fellow) in an ACGME- or ADA-accredited training program? (If yes, proceed to next item; if no, skip to item 6).

2. Date Graduated: _____ Degree awarded: _____

3. **Prior residencies or fellowships:**

- a. Specialty: _____ Dates: _____
- b. Specialty: _____ Dates: _____
- c. Specialty: _____ Dates: _____
- d. Specialty: _____ Dates: _____

4. ***USMLE Step 1** Score: _____ Date Taken: _____

***USMLE Step 2** Score: _____ Date Taken: _____

***USMLE Step 3** Score: _____ Date Taken: _____

(must provide copies of scores from the licensing board)

5. ***ECFMG Number** (if applicable): _____ Date Valid: _____

(must provide copy of certificate)

6. ***Licensing**

State: _____ Expiration Date: _____

State: _____ Expiration Date: _____

DEA Number: _____

(if you do not have one a temporary number will be assigned)

Have you been offered the Hepatitis-B vaccine? (Please circle) Yes No

If yes, did you receive it and when? _____

***I attest that the information that I have provided (including rotation dates) is accurate to the best of my knowledge.**

Signature

Date



CHILDREN'S NATIONAL MEDICAL CENTER EMPLOYEE CONFIDENTIALITY AGREEMENT

Employee Name _____ Employee ID: _____

(last 5 digits of SSN)

Employee Department _____

Children's National Medical Center is committed to maintaining the highest standards of confidentiality. Recognizing that preserving confidential information rests with each employee, the intent of this statement and agreement is to alert employees to their specific responsibilities.

I, the undersigned, acknowledge that I understand and agree to adhere to the following statements:

1. I will abide by the provisions set forth in the CNMC Confidentiality Policy (CH:HR:64), CNMC Information System Security Policy (CH:A:27) and CNMC Appropriate Use of Information Resources Policy (CH:A:32).
2. **All patient information** (oral, written or electronic, past, present and future, medical, financial or demographic) will be held to the highest level of confidentiality. I will not release, discuss, or disclose any patient information that is not allowed under Federal HIPAA Regulations, or is appropriately authorized or is required by law.
3. I understand that in the performance of my duties I may have access to **sensitive information** and/or reports related to other employees, organizational design or systems design, source codes, business and financial planning or status and other information related to organizational performance, planning, and development. I agree that I will not disclose such information.
4. **System Security and Access:**
 - a. I consider my CNMC logon ID to be the equivalent of my signature and I am responsible for all entries made under my logon ID.
 - b. I will maintain proper password security by not revealing my password to anyone.
 - c. I will protect the security of the CNMC Information Systems by not providing anyone else access to the information system.
 - d. I will not leave my work station /terminal unprotected while I am logged onto the CNMC Information System
 - e. I will report suspected security violations immediately to my Supervisor or the Security Coordinator or Director of my Department
 - f. I will access information resources specifically computer systems, only for purposes related to the performance of my assigned job responsibilities.
 - g. I understand that CNMC reserves the right to monitor information systems file access at any time. I will cooperate with periodic necessary inspection of data and equipment assigned to me.
 - h. I understand that all CNMC systems and applications belong to the organization. As such, CNMC has the right to audit, monitor, and inspect all information on the systems including but not limited to use of e-mail, databases, and documents.
5. I understand that this form will become an official part of my employee file. Failure to comply with the provisions in this document as well as the policies referred to within it, will result in disciplinary actions up to and including termination of employment from Children's National Medical Center.

Employee Signature _____ Date: _____



CHILDREN'S NATIONAL MEDICAL CENTER
 IDENTIFICATION BADGE / BUILDING / PARKING ACCESS REQUEST FORM

1 CONTACT INFORMATION:

Last Name: _____
 First Name: _____
 Middle Initial: _____
 Address: _____

Today's Date: ___/___/___
 Title: MD DDS DMD
 PHD RN

City: _____ State: _____ Zip Code: _____

2 BADGE TYPE: ID Only Building Access Only Parking/Building Access

3 CNMC STAFF:

Employee ID Number: _____
 Department/Unit Assigned: _____
 Ext. _____
 Position Title: _____

4 NON-CNMC STAFF:

Check one: Agency/School/Company/Other
 Board Member _____
 Community Based MD _____
 Contractor _____
 Resident/Fellow/MD _____
 Student _____
 Temporary _____
 Volunteer _____
 Other _____

AUTHORIZATION FOR MONTHLY PAYROLL DEDUCTION FOR PARKING:

What is your work schedule Monday through Friday: _____

I authorize \$25.00 \$49.00 \$85.00 to be deducted from my paycheck for monthly parking.

Signature: _____

Department/Unit Assigned: Extension: _____

Term of Assignment: FROM ___/___/2005 TO ___/___/20___

There is a monthly parking fee for parking access. A monthly parking fee must be paid each month for parking access to continue.

5 PARKING INFORMATION:

Handicap Tag: YES NO

Vehicle Make and Model: _____
 License Plate: _____

Color: _____
 State of Registration: _____

6 RESTRICTED ACCESS: (Authorized signature must be completed prior to access being given.)

Administration – Denise Gravely Price (5402) _____	Bone Marrow – Karen Kaucic (3217) _____
Engineering – Pres Andam (2040) _____	MIS – Kelly Styles (3792) _____
Pharmacy – Karl Gumper / or (2689) _____	Animal Lab – Elizabeth Broussaro (3182) _____
Karla Evans (5020) _____	MRI - LaVerne Naughton (5085) _____
Child Protection – Herman Tolbert (6717) _____	Library - Deborah Gilbert (3195) _____
Operating Room – Gayle Eward / or (3607) _____	Research – Trish Higdon (4875) _____
Andrea Gardner (6006) _____	Cath Lab- Jeanne Ricks (4809) _____

7 AUTHORIZED BY: (** Signature Required)

Printed Name _____ Signature _____ EXT. _____

**New hires / Temp. Employees – Human Resources; **Volunteers – Volunteer Services; **Students - Instructor;
 **Residents/Contractors/Consultants/ Others – Department Head; **Community Based Physicians - Medical Staff Office;
 **Board Member – Carl Spatz

Status Level: _____
 Hanging Permit Tag number: _____
 Date entered into Geoffrey System : _____

Encoded ID Number: _____
 Parking Level Assignment: _____
 Updated in Geoffrey System: _____

(Completed by parking office staff)



ORIENTATION BROCHURE ACKNOWLEDGEMENT

I acknowledge receipt of my copy of the Contract/Agency/Non-Agency/Volunteer Orientation Brochure and understand that it is my responsibility to know and abide by its contents.

Print Name: _____

Signature: _____

Date: _____

Department: _____



WEB BASED TRAINING INSTRUCTION SHEET FOR ROTATING TRAINEES

1. Clinical Transformation Initiative (CTI) went live on Dec 4th, 2005. As a result, all rotating trainees will be required to go through CTI training.

Go to <http://www.dcchildrens.com/dcchildrens/fordocors/wbt.aspx>

The trainee will view the module applicable to them. Trainees who will be entering orders in the system are required to take the Inpatient Provider course; all other trainees will be required to take the View only for outpatient provider module.

After you have chosen the appropriate module, you are asked for a log in and password which is:

Log in: ROTATINGDOC (uppercase letters)

Password: TRAINME (uppercase letters)

2. All trainees will be required to demonstrate their competency after viewing the modules. Competency tests can be accessed through <http://chexweb.knowledgeplanet.com> . This website will require a password. Please contact the Medical Staff Office to obtain our login information and password. CHEX ID will be given out only after you have provided the Medical Staff office with all the other documentation required to process your application.

****Please type the test as written below in the search area to ensure you have the correct test**

 **CNMC - CTI Competency for Inpatient Provider**

OR

 **CNMC - CTI Competency for View Only, Outpatient Providers**

 **CHEX - Bloodborne Pathogens V4.0**

 **NEW EMPLOYEE ORIENTATION - SAFETY COMPLIANCE QUIZ**

3. In order to pass the competency test, trainees will be required to achieve a score of at least 80% on the test. If the trainee is unable to pass the test in more than 3 attempts, remedial training will be required.

****Please note that if you are experiencing difficulty logging on to the site, please disable any pop-up blockers.**