APPLICATION FOR ROTATION INTO KARMANOS CANCER CENTER

GENERAL INSTRUCTIONS for KCC ROTATIONS

Application and attachments must be received by KCC no later than 8 weeks prior to the start of the rotation requested.

No application will be processed unless all sections are complete and all required attachments accompany the application, including the completed Confidentiality Statements to insure issuance of CIS access codes. Part I and Part II must be completed by the applicant and the applicant's Program Director, respectively.

FOLLOW UP INFORMATION

1. The KCC GME Office will notify the Program Department to inform them whether the rotation has been approved or rejected by KCC Administration.
2. Applicant will then be contacted by the WSU Program Director's Office 4 weeks prior to the start of the rotation to notify applicant if his/her request has been approved or rejected.
3. The WSU GME Office will input the rotations into the New Innovations system after they are approved by KCC Administration.

INSTRUCTIONS FOR WSU PROGRAM DEPARTMENT- PART IV

Part IV is to be completed by the Program department signed by the Program Director. Please make sure the rotation name is entered exactly as it appears in New Innovations.

The Program will keep a copy of the completed paperwork, including all signatures, and forward the entire file to the KCC Office.

VIA FAX: 313-576-8627

VIA EMAIL: Shockk@karmanos.org

VIA DROP-OFF:
KCC GME OFFICE
4100 John R, 2nd Floor, Executive Offices
Call Karen Shock at (313)576-8527 for questions.

APPLICATION FOR ROTATION INTO KARMANOS CANCER CENTER

Part I- APPLICANT

Applicant Name: _____ Social Sec # : _____

Date of Birth: _____ Home Phone # : _____ Email: _____

Medical School: _____ MTH/DY/YR of Graduation: ___/___/____

ECFMG Certificate Number (if FMG): _____ ECFMG Certificate Date: ___/___/____

Current Training Program: _____ Institution: _____

Current Training Program Start Date___/___/___Current Post Graduate Year (PGY) Level as of today's date:____

Name of Program Director _____ Phone # : _____

TRAINING GAPS: Please account for your activities during any training gaps:

From _____ to _____
(ECFMG Date- If no ECFMG, use Med School Grad Date Instead) (Start Date of Current Training Program)

☐ I was in an accredited US residency/fellowship program in _____
Program Specialty

at _____ from ___/___/___ to ___/___/___
Hospital/Institution Name Start Date End Date

☐ I was in an unaccredited or foreign residency program in _____
Program Specialty

at _____ from ___/___/___ to ___/___/___
Hospital/Institution Name Start Date End Date

☐ I was in military service in the _____ from ___/___/___ to ___/___/___
Branch of Armed Forces Start Date End Date

☐ Other: I was involved in the following activities (i.e., volunteer work, research, studying, other Employment, travel, etc.): Use additional sheet if necessary.

	Start Date	End Date
_____	___/___/___	to ___/___/___
_____	___/___/___	to ___/___/___

OTHER

Date of Last TB Skin Test: ___/___/___ Results: ☐ Negative ☐ Positive* *If TB skin test was positive, you will need to submit evidence that a chest X-Ray has been performed and reviewed by a physician.

Emergency Contact Name: _____ Phone # : _____

Address: _____ Relationship: _____

I hereby verify that the information and documents contained in this application are accurate, authentic, and complete.

Signature of Applicant: _____ Date ___/___/____

PART II – PROGRAM DIRECTOR (to be completed by Home Institution's Program Director)

Applicant Name:_____ Rotation Dates: FROM__/__/__TO__/__/__

WSU Program Name: _____

Rotation Description:_____

Based upon my program curriculum, the requested rotation is a : ☐ Core Rotation ☐ Elective Rotation

A. I verify that:

1. The above named Resident/Fellow is a trainee in good standing in a program which I direct and there have been no licensing, liability, disciplinary or other problems with the applicant.
2. The above named Resident/Fellow has received all Hazardous materials training and Universal Precautions training and exposure to Blood Borne Pathogens training as required by the State of Michigan and Federal Law.
3. If the above named resident is a Foreign Medical School Graduate (FMG), I certify that I **have/ have not** given credit toward their current training program for any foreign/overseas training done in the past. **(circle one)**

B. Please indicate the percentage of time your Resident/Fellow will spend during the requested Rotation at:

KCC**_____% + Other Hospital(s)_____% = 100%
(Indicate Location)

C. I have attached copies of the following documentation:

☐ ERAS and/or GME Application ☐ CV

☐ ECFMG Certificate for FMGs ☐ Medical School Diploma

☐ Valid Michigan License to Practice Medicine ☐ Resident Home Program Accreditation Letter

☐ Resident's Home Institution Rotation Schedule covering the time period of the Rotation being requested.

Applicable☐ N/A☐ Verification of malpractice coverage from home institution if no reciprocal agreement.

Applicable☐ N/A☐ Evidence of a chest X-Ray if TB skin test was positive.

Signature of Program Director: _____ Date ___/___/___

Printed Name: _____ Email Address: _____ Phone # _____

PART III- TO BE COMPLETED BY KCC PROGRAM:

FROM___/___/___**TO**___/___/___

Rotation Name per New Innovations: _____

Approved ☐ Yes ☐ No

Signature of WSU Program Director: _____Date___/___/___

Printed Name: _____ Email Address: _____ Phone # _____

PART IV- TO BE COMPLETED BY KCC ADMINISTRATION FOR KCC ROTATIONS

Approved ☐ Yes ☐ No Signature of KCC Officer: _____ Date___/___/___

BARBARA ANN
KARMANOS
CANCER INSTITUTE

CONFIDENTIALITY OF INFORMATION STATEMENT

All Karmanos employees, physicians, residents, students, volunteers and vendors must sign this document prior to being assigned duties, a computer access code or password authorization. **No alterations to this statement are allowed.**
As an individual working or assigned to the Karmanos Cancer Center, Karmanos Cancer Institute or any affiliate thereof, (faculty or staff at the Detroit Medical Center, or any professional association or other entity associated with the Wayne State School of Medicine, or any subsidiary or affiliate thereof), I understand that information is required for me to perform my duties. Some of this information may concern patients being treated at Karmanos Cancer Center and/or Karmanos Cancer Institute or it may concern the operations of Karmanos Cancer Center and/or the Karmanos Cancer Institute. I understand that patient medical information belongs to the patient and that I am only permitted to access patient medical information to the extent that it is necessary to provide patient care or perform my duties. I also understand that all medical and personal information regarding patients is confidential and, unless directly related to the care of patients and authorized by Karmanos Cancer Center or the Karmanos Cancer Institute policy, should not be revealed or discussed with other patients, friends or relatives, or anyone else within or outside Karmanos Cancer Center or the Karmanos Cancer Institute healthcare environment.

I also understand that other information regarding the operations of Karmanos Cancer Center or the Karmanos Cancer Institute is confidential. This includes any information regarding employees, financial operations, quality assurance, utilization review, risk management, research, procurement, contracting and credentialing of staff. I understand that I am only authorized to access this information if it is required for me to perform my duties. This information should not be revealed or discussed with others within or outside Karmanos Cancer Center or the Karmanos Cancer Institute, except to the extent that this discussion is necessary to perform my duties.

I also understand that I may not view my own medical record without proper authorization in accordance with policy HIM 020, Release of Information. I shall not electronically access my own medical records, or that of my family members, including lab or test results, except as a legitimate function of my job duties or with proper authorization in accordance with policy HIM 020, Release of Information.

I understand that I am required to protect any KCC and KCI patient or operations information from loss, misuse, unauthorized access, or unauthorized modification, and to report any suspected breach of security policies.

I understand that I may be given access codes or passwords to Karmanos Cancer Center and/or Karmanos Cancer Institute computer systems. I will safeguard the security codes and passwords given me. I acknowledge that I am strictly prohibited from disclosing my security codes to anyone including my family, friends, fellow workers, supervisors, managers and subordinates, for any reason.

I understand that I may use my access security codes to perform my duties only. I agree that I will not use anyone else's security codes to obtain access to any computer systems. I understand that I will be held accountable for all work performed or changes made to the system or databases under my security codes and that I am not to allow anyone else to access the computer using my security codes, or leave my computer unattended and permit anyone else to access the system through my computer password.

I understand that failure to follow the confidentiality of information statement is cause for termination of employment, revocation of privileges, or revocation of access to Karmanos Cancer Center and Karmanos Cancer Institute; any such occurrence may be noted in my student, personnel, vendor record or credentialing file and may result in notice to my educational institution, my agency or employer, if such a relationship exists.

I, the undersigned, also hereby acknowledge receipt of a copy of the Confidentiality Policy, HR 200, of Karmanos Cancer Center as well as Karmanos Cancer institute and agree that I: (i) have read and understand the Confidentiality Policy, (ii) shall comply with and be bound by the terms of the Confidentiality Policy and (iii) understand the requirement that all patient information be kept confidential. I shall comply with all relevant state and federal confidentiality laws including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and all HIPAA policies and procedures of KCC and KCI.

Signature _____ **Date** _____

Print Name (First, Middle Initial, and Last) _____

Department _____ **Hospital/Worksite** _____

List All User ID's _____

Employee # _____ **Work Phone Number** _____

Security Questions:

Mother's maiden name: _____ **First school attended:** _____

This form must be fully completed, signed and submitted to KCI security prior to system access being granted to ANY user.

Please file in student, personnel, volunteer record or in physician credentialing file. 05/2014

EXHIBIT B

STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of _____("Karmanos Cancer Center"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the Program at Karmanos Cancer Center unless such injury or loss arises solely out of Karmanos Cancer Center's gross negligence or willful misconduct.

Dated this _____ day of _____, 20__.

_____
Resident

_____
Witness

Karmanos Cancer Center
Graduate Medical Education
Parking Identification Data/Input Card

Please Print

SHADED AREA FOR OFFICE USE

Last Name	First Name	Middle Initial
Location/Department	**Karmanos**	**Personal Contact #**
KCC GME Office	**(313)576-8527**	**Resident/Fellow** **Resident**

DATES OF ROTATION: _____

PARKING LOCATION: NORTH DECK

Vehicle Information

Make & Model	Year & Color	License Plate# & State	Hanging Tag #
Make & Model	**Year & Color**	**License Plate# & State**	**Hanging Tag #**

Please check if applicable:

☒ ID badges must provide access to the Harper University Hospital operating room, Harper Inpatient floors & associated surgical areas.

Authorizing Person _____ Date: _____

David Jansen, Vice President-Human Resources

Please be advised that parking & badges require a $10.00 fee (Cash Only)

DMC
DETROIT MEDICAL CENTER

Confidentiality of Information Statement for Non-DMC Employees

This document must be signed by all **Non-DMC employees** prior to being assigned duties or a computer access code or password authorization. **No alterations to this statement are allowed.**

As an individual providing services to, on behalf of, or for the benefit of the DMC or any parent, subsidiary, affiliate or successor thereof, I understand that information to which I have access in the performance of my duties is confidential. This duty of confidentiality applies to both individuals and entities. I understand that I am only permitted to access patient medical information to the extent that it is necessary to provide patient care or perform my duties. I also understand that all medical and personal information regarding patients is confidential and unless directly related to the care of patients and authorized by DMC policy, should not be revealed or discussed with other patients, friends or relatives, or anyone else within or outside the Detroit Medical Center healthcare environment.

I also understand that other information regarding the operations of the DMC is confidential. This includes any information regarding employees, financial operations, quality assurance, utilization review, risk management, research, procurement, contracting and credentialing of staff. I understand that I am only authorized to access this information if it is required in order for me to perform my duties. This information should not be revealed or discussed with others within or outside the DMC except to the extent that this discussion is necessary to perform my duties.

I also understand that I may not view my own medical record without the proper authorization. I shall not electronically access my own medical records, or that of my family members, including lab or test results, except as a legitimate function of my job duties or with proper authorization.

I understand that I am required to protect any DMC patient or operations information from loss, misuse, unauthorized access or modification, and to immediately report any suspected breach of security policies.

I understand that I may be given access codes or passwords to DMC computer systems. I will safeguard the security codes and passwords given to me. I acknowledge that I am strictly prohibited from disclosing my security codes to anyone including my family, friends, fellow workers, supervisors, and subordinates for any reason. I agree DMC data and EPHI reside and shall be stored ONLY on DMC servers and NOT on any laptop, PCs nor any other device whether owned by DMC or not.

I understand that I may only use my access security codes to perform my duties. I agree that I will not use anyone else's security codes to obtain access to any computer systems. I understand that I will be held accountable for all work performed or changes made to the system or databases under my security codes. I will not allow anyone else to access the computer using my security codes. I will not leave my computer unattended. I agree to defend, indemnify and hold harmless the DMC, its employees, subsidiaries and affiliates against all claims, losses and damages including reasonable costs and expenses resulting from my breach of this Confidentiality of Information Statement. I understand that failure to abide by the terms of this Confidentiality of information Statement is cause for revocation of privileges, or revocation of access to the DMC, and may be noted in my student record, and may result in notice to my educational institution or my agency or employer, if such a relationship exists.

Signature	**Date**	**List all User IDs used**

Completion of this section is required for System/Network Access. Personal Verification Data – Please complete all of the following:

Please PRINT Legibly: First, Middle, and Last Name (full legal name please)

Dept. Name:	Hospital/Site Division:
Last 4 digits of SSN:	Date of Birth:
Mother's Maiden Name:	Work Phone Number:
First school you attended:	Phone Number (other):
Favorite Pet:	Pager Number (if applicable):

Scan and send as .PDF file to sfax@dmc.org or Fax to (313) 578-2728. All Pages Must Be Single Sided. Form updated on 10/05/12

Instructions for Individual Confidentiality Statement Completion

Please print and read confidentiality statement thoroughly.

Using Pen, print your full legal name, sign and date the form then complete the questions pertaining to: mother's maiden name, first school attended and favorite animal or pet. The Help Desk or Security will ask you to answer these questions to verify that you are indeed the person to whom the NT ID belongs. **NOTE: Failure to complete the confidentiality statement as instructed will lead to delays in access and will require re-submission of a properly completed Confidentiality Form.**

Please scan the completed form as a .PDF file and email it to sfax@dmc.org or fax it to (313) 578-2728.

NOTE: Managers (or anyone) submitting a Confidentiality Statement on behalf of another person must NOT retain the original or a copy of the completed form as this is a violation of DMC policy. The form must be returned to the owner, or destroyed on confirmation of a successful transmission.

You may keep your own completed Confidentiality Form in a secure place. Remember, the personal identifying information is your information and must not be shared or left where others may see or obtain it.