MILITARY/ELECTIVE ROTATOR CHECK LIST

NAME: ________________________________________________________________

1. Application (completed) ______________________

2. Current permit/license ______________________

3. Immunization Record
   (Current PPD/Hep B) ______________________

4. CPR ______________________

5. Clearance Form ______________________
1. Military rotators cannot in-process at University Health System until they have been cleared for the rotation by the UTHSCSA GME Office.

2. Military rotators must in-process for each rotation at University Hospital and provide an updated rotator packet. They are to report to Professional Staff Services on the 1st Floor of University Hospital, next to the "S3" elevators, Room g0124 before they report to their assigned service.

3. Packets must have current rotation information and signature dates. Any packets received with previous rotation information will not be accepted.

4. The rotator will be required to provide current documentation of the following:
   a. A PPD reading within one year of current rotation. If PPD positive they must be able to provide a negative chest x-ray dated after the positive PPD reading.
   b. Proof of Hepatitis B #3 and HepB antibody titer
   c. TDAP Booster in Adulthood
   d. Documentation of current influenza vaccine
   e. Current CPR (BLS, ACLS, ATLS, etc.)
   f. Current Texas training permit or Texas medical license. University Hospital will not accept a license from another state. Physician Assistant Rotators must be able to provide a Texas PA License, DPS, and Federal DEA Certificate.
   g. In order to receive parking, the rotator will need to bring current vehicle registration and proof of insurance. On the day of in-processing, they may park in UHS visitor parking and have their ticket validated at Registration and ID.
   h. Paperwork for ID and parking, as well as computer access, will not be issued until all requirements have been met. Paperwork can be faxed or emailed to our office prior to the rotation date.

**PROFESSIONAL STAFF SERVICES CONTACTS**

<table>
<thead>
<tr>
<th>CONTACT</th>
<th>TELEPHONE</th>
<th>FAX</th>
<th>EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marilyn Dahl</td>
<td>(210) 358-0062</td>
<td>(210) 358-4775</td>
<td><a href="mailto:Marilyn.dahl@uhs-sa.com">Marilyn.dahl@uhs-sa.com</a></td>
</tr>
<tr>
<td>Adelfa Diaz</td>
<td>(210) 358-0163</td>
<td>(210) 358-4775</td>
<td><a href="mailto:Adelfa.diaz@uhs-sa.com">Adelfa.diaz@uhs-sa.com</a></td>
</tr>
</tbody>
</table>

REVISED 12/16/14
# University Health System

## MILITARY/ELECTIVE ROTATOR APPLICATION

<table>
<thead>
<tr>
<th>Primary Duty Assignment:</th>
<th>□ SAMMC □ WHMC □ OTHER (Please Specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current PGY Level:</td>
<td># Past Training Years:</td>
</tr>
<tr>
<td>Initial Specialty:</td>
<td>Current Specialty:</td>
</tr>
<tr>
<td>Current Program Director:</td>
<td>Director's Telephone:</td>
</tr>
<tr>
<td>Current Rotation:</td>
<td>Rotation Dates: From: To:</td>
</tr>
</tbody>
</table>

## ROTATOR PERSONAL DATA

- Rotator Name: 
- Last Name: 
- First Name: 
- MI: 
- Street: 
- Apt.: 
- City, State, Zip: 
- Local Telephone Number: 
- Pager Number: 
- Social Security Number: 
- Date of Birth: 
- Citizenship: 
- Gender: □ Male □ Female 
- Ethnicity: 

## ROTATOR EDUCATION AND LICENSE DATA

- Medical School: 
- Graduation Date: (Month, Day, Year) 
- Degree: 
- Permit/License Number: 
- Expiration Date: 
- Current CPR Type: 
- Expiration Date: 
- DEA (if applicable): 
- DPS (if applicable): 

## ROTATOR EMERGENCY CONTACT DATA

- Emergency Contact 1: 
- Contact Name: 
- Relationship: 
- Contact Number: 
- Emergency Contact 2: 
- Contact Name: 
- Relationship: 
- Contact Number: 

___

Rotator’s Signature: 
Date: 

****STOP FOR PROFESSIONAL STAFF SERVICES DEPARTMENT USE ONLY****

<table>
<thead>
<tr>
<th>Rotator ID Number:</th>
<th>Prescription Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Immunizations: □ Yes □ No License Verified: □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Current CPR: □ Yes □ No Data Entry Completed: □ ECHO</td>
<td></td>
</tr>
</tbody>
</table>
CREDENTIALED PROVIDER ACCESS REQUEST FORM

Please complete all of the information below. Incomplete forms will be rejected.

TODAY'S DATE: __________

NAME: ____________________________

LAST NAME   FIRST NAME   MI

LAST 4 DIGITS OF SSN: ______________________

DEPARTMENT/SPECIALTY NAME: ______________________________________

NETWORK USER ID (if known): __________________________

PROVIDER'S TITLE: ____________________________________________

PHONE/PAGER NUMBER: ___________________________ EXT. ______

BUSINESS EMAIL ADDRESS: ______________________________________

CREDENTIAL: ____________________________ (MD, DDS, DO, PA, NP, etc.)

<table>
<thead>
<tr>
<th>PROVIDER ID#</th>
<th>STATE LIC/PERMIT#</th>
<th>NPI#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ CMA (add roles-cma-cqi users)  ☐ ATTENDING (add to sunrise attending dictionary)

☐ MEDICAL-DENTAL STAFF  ☐ ALLIED HEALTH

PRESCRIPTIVE AUTHORITY:
☐ NONE: (MD wo RX AUTH security group or see role base matrix for non MD’s, issue this group if no other box selected)

☐ NON NARCOTICS ONLY: (MD SUS DEA security group)

☐ NO RESTRICTIONS: (MD security group) DEA#: __________  DPS#: __________
[If DEA or DPS license is pending, select NON NARCOTICS ONLY box]

☐ HOUSESTAFF  ☐ MILITARY / ELECTIVE ROTATOR ( ________ )

DEA#: AM1472579  DPS#: 10046768

If different from above

DEA#: __________  DPS#: __________

If different from above

(MD security group)

AUTHORIZATION:
(Professional Staff Services)

PRINT: ____________________________

NAME   TITLE

SIGNATURE: ____________________________________________

Have questions? Call Data Security at 358-0640. Scan & email completed requests to DataSecurityScannedRequests@uhs-sa.com.

Rev. 02/12
UNIVERSITY HEALTH SYSTEM
CONFIDENTIALITY AGREEMENT

I, the undersigned, hereby acknowledge receipt of a userid and password giving me access to the Hospital Information System of the University Health System, Bexar County, Texas (hereafter referred to as the University Health System) computer system. I understand and acknowledge that this userid and password combination is unique to me and is the electronic equivalent of my signature, with no difference in liability existing between my written and electronic signatures.

I further understand that this userid and password may give me access to confidential patient health care and financial information, employee personnel information, physician information, and business information relating to the University Health System (herein referred to as Information), and that the University Health System regards maintaining the confidentiality of this information to be of paramount importance.

Therefore, in consideration of the foregoing, I agree to the following:

1. Information to be confidential. All Information obtained by me, or on my behalf, whether by me, my office staff, agents, employees or any other person whatsoever, will be maintained in confidence by me, or by any other person acting on my behalf. I further agree that Information will be obtained and used only as necessary to perform my professional responsibilities.

2. Scope of Information. I agree that I will use the userid and password only to obtain access to that Information necessary for me to perform my Professional responsibilities.

3. Use of Userid, Password and Signature Stamp. I will not disclose my userid and password to any person or entity, nor will I attempt to learn or use any other person's userid and password. I will not share my Signature Stamp with any person.

4. Issuance of New Userid and Password. If I have any reason to believe that the confidentiality of my userid and password has been compromised, I will notify the Data Security Administrator immediately so that the suspect userid and password may be deleted and a new userid and password assigned to me.

5. Responsibility for Self. I recognize that I am responsible for all actions performed at a workstation activated with my userid and password; therefore, I will terminate the session before leaving the workstation.

6. Responsibility for Others. If applicable, I hereby specifically accept responsibility for ensuring that my office staff, agents, employees, or any other person acting on my behalf, in connection with Information, will abide by the terms and conditions of this Confidentiality Agreement.

7. Violation of Conditions. I recognize that violation of any of these conditions may result in withdrawal of computer access, termination of employment for employees, denial of hospital access for non-employees, and other disciplinary actions.

8. Indemnification. I agree to indemnify and hold the University Health System harmless from any and all liability, loss, or damage, including attorney's fees, that the University Health System may suffer as a result of claims, demands, costs, or judgments against it arising from the breach or violation of any provisions of this Agreement by me and/or my staff, agents, employees, or any other person acting on my behalf. I further agree to notify the University Health System in writing, within ten (10) days by registered U.S. Mail, of any claim made against me or my office staff, employees, and/or agents, on the obligations indemnified against herein.

I have also received, read, and understood the Information Asset/Use Policy 2.08.02

IN WITNESS WHEREOF, I have executed this agreement at San Antonio, Texas, this __________ day of __________, 20 ___.

HOSPITAL INFORMATION SYSTEM USER     WITNESS

PRINT: ___________________________     PRINT: ___________________________

SIGNATURE: ______________________     SIGNATURE: ______________________

USER'S LEGAL SIGNATURE (AS IT APPEARS ON LICENSE): __________________________
**Protective Services Registration/Access/ID Form**

<table>
<thead>
<tr>
<th>DATA CHANGE</th>
<th>UHS EMP</th>
<th>MEDICAL STAFF</th>
<th>UTHSCSA STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAL STUDENT</td>
<td>RESIDENTS</td>
<td>VOLUNTEERS</td>
<td>MILITARY</td>
</tr>
<tr>
<td>OBSERVER</td>
<td>CONTRACTOR</td>
<td>VENDOR</td>
<td></td>
</tr>
</tbody>
</table>

**FACILITY LOCATION:**

<table>
<thead>
<tr>
<th>NAME (LAST, FIRST MI)</th>
<th>Emp ID #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DRIVERS LICENSE NUMBER &amp; STATE</th>
<th>DATE OF BIRTH</th>
<th>SS# (Last 4 #s)</th>
<th>MAIL STOP#</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DEPARTMENT / SCHOOL NAME</th>
<th>POSITION/TITLE</th>
<th>CREDENTIALS:</th>
<th>PHONE #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>EMAIL ADDRESS</th>
<th>ID CARD #: (R&amp;I Use Only)</th>
</tr>
</thead>
</table>

**PARKING PERMIT DATA (Primary Vehicle)**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MAKE</th>
<th>MODEL</th>
<th>COLOR</th>
<th>BODY SYTLE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LICENSE PLATE NUMBER - or - VEHICLE IDENTIFICATION NUMBER</th>
<th>STATE OF ISSUE</th>
</tr>
</thead>
</table>

**PARKING PERMIT NUMBER** *(Office Use Only)*

**PARKING PERMIT DATA (Secondary Vehicle)**

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MAKE</th>
<th>MODEL</th>
<th>COLOR</th>
<th>BODY SYTLE</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>LICENSE PLATE NUMBER - or - VEHICLE IDENTIFICATION NUMBER</th>
<th>STATE OF ISSUE</th>
</tr>
</thead>
</table>

**PARKING PERMIT NUMBER** *(Office Use Only)*

**AUTO INSURANCE**

<table>
<thead>
<tr>
<th>ALLSTATE</th>
<th>GEICO</th>
<th>LOYA</th>
<th>NATIONWIDE</th>
<th>PROGRESSIVE</th>
<th>STATE FARM</th>
<th>USAA</th>
<th>OTHER:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>EXPIRATION DATE</th>
</tr>
</thead>
</table>

**UTHSCSA EMPLOYEES (PAID RECEIPT REQUIRED FOR ALL UTHSCSA NON PROVIDERS)**

6 MONTHS/ $60 PAID TO CASHIER - RECEIPT VERIFIED BY: 12 MONTHS / $120 paid to cashier - receipt verified by:

I have been informed of my proper parking area and I have received information regarding the Health Systems' parking policies, rules and regulations. I understand that, though my vehicle is properly registered, I am not guaranteed a parking space and any violations of UHS parking policies, rules and regulations may result in revocation of parking authorization and/or towing of my vehicle at my risk and expense. I further understand that all items issued to me by Protective Services through Employee Registration and Identification are security controlled items. It is my responsibility to safeguard these items. Any loss of these items must be reported immediately. A replacement fee will be assessed for any items lost, stolen, damaged or not returned. The University Health System assumes no liability or responsibility for any personal property on Health System premises.

Replacement fees are established by Protective Services in accordance with established polices & procedures.

**SIGNATURE**

**DATE**

**RETURN TO:**

MAIL STOP 30-1; FAX 358-0105 OR EMAIL TO:

Vinnie.Montanarello@uhs-sa.com or Veronica.Cuellar@uhs-sa.com

Rev 12/15/2014
MILITARY/ELECTIVE HOUSE STAFF CLEARANCE FORM

Please have each military or elective rotator complete at the end of his/her rotation. This form needs to be taken to the Professional Staff Services office for final clearance once Sections 1-4 have been completed. Thank you.

Name ___________________________ Department ___________________________

1. ___________________________ ___________________________
   UTHSCSA Residency Program Date ___________________________

2. ___________________________ ___________________________
   Medical Records (1ST FL. Elevator A) Date ___________________________

3. ___________________________ ___________________________
   ID. (ID Badge & Parking Tag Sublevel-Elevator A) Date ___________________________

4. ___________________________ ___________________________
   Laundry Services (Scrubs) (if applicable—Sublevel-Elevator A) Date ___________________________

5. ___________________________ ___________________________
   Professional Staff Services Date ___________________________