

Military Rotators

In-Processing Packet

Military Rotator Packet

Purpose

To ensure that accurate information on military residents rotating on one of the sponsored programs' rotations is entered into New Innovations. Back-up documentation is required by the UTHSCSA Graduate Medical Education Office in case of an audit.

Goal

To ensure each military resident has provided the necessary documentation to allow him/her to begin his/her rotation with minimal problems.

UTHSCSA GME Contact:

MedGME@uthscsa.edu

210-567-4431

Location of Packet on UTHSCSA GME Website:

<http://www.uthscsa.edu/gme/documents/Military%20Rotator%20Packet.pdf>

MILITARY ROTATORS – CLINICAL ROTATION REQUIREMENTS

Military Rotators from outside of any UTHSCSA program.

*Instructions: Complete and return to the Associate Dean of Graduate Medical Education for review. **The program is responsible for insuring the resident is processed in at the appropriate facilities (UHS and/or VA) as noted in the section, "FINAL PROCESSING."***

	Documents to Submit to GME Office, completed and signed.
	1. The University of Texas Health Science Center at San Antonio, Housestaff Data Sheet – GME Office. GME must have this within 7 business days prior to start of rotation to insure receipt of a UTHSCSA badge.
	2. "Notice for Voluntary Disclosure of Social Security Number" form.
	3. "Confidentiality/Security Acknowledgement" Form – <i>only return the last page.</i>
	4. Read and complete "VHA Privacy Policy Training" (HIPAA requirement) – <i>only return the test.</i>
	5. Read and complete the American Medical Association document (Ethics) – <i>only return the last page.</i>
	6. If you will be rotating at the VAH, there are other training modules that need to be completed. These can be found at www.uthscsa.edu/GME/incomingresidents.asp , Step Three, Item numbers 8 and 9.
FINAL PROCESSING (After GME Review) – see the specialty program coordinator for information	
	UTHSCSA
	ID Badge
	University Hospital System (UHS) – Professional Staff Services
	UHS Application (to be completed in the office of Professional Staff Services).
	Immunization records showing a PPD within one year and a Hepatitis B series of three vaccinations or Hepatitis B Titer. <i>If rotator is PPD positive, they must provide a copy of chest-ray results dated after the positive results.</i>
	VA Hospital (VAH) – report to ACOS/Education Processing on or before the first day of rotation and bring:
	Completed VAH application and other required paperwork.
	Completed TQVCL attachment

Academic Year _____
The University of Texas Health Science Center at San Antonio
Housestaff Data Sheet for Military Rotators

Name:

(Last) (First) (Middle) (Degree Type) (Gender)

Local Address:

(Street) (City) (State) (Zip Code)

**Work E-mail
address:**

Phone Number:

(Home) (Cell) (Pager)

Date of Birth:

_____ **Social Security #:** _____

**Medical
School:**

(name) (location)

**Current Residency/Fellowship
Program**

(specialty)

Items listed below will be required for in-processing at area hospitals.

- Certifications (current)
 - Basic Life Support
 - Advanced Cardiac Life Support
 - Advanced Trauma Life Support
- Medical Licensure
 - Physician In-Training Permit
 - Texas Medical License
 - Federal DEA
 - Texas DPS
 - Other Medical License (if rotating only at the VA)
- National Provide Identifier
- Immunization Proof
 - Hep B #3
 - PPD within one year of rotation start/end
 - If positive PPD, must provide chest-ray results dated after the positive PPD

****MUST BE COMPLETED AND RETURNED WITHIN FIVE (5) BUSINESS DAYS****

USER ACKNOWLEDGEMENT FORM

ACCEPTABLE USE: The University of Texas Health Science Center at San Antonio provides Information Technology (IT) primarily to support its missions and business functions. All other uses are deemed secondary and may be subject to additional restrictions. Uses that threaten the availability, confidentiality and integrity of any system may be considered illegal and is prohibited. All users are responsible for the information assurance and security of University-owned or operated information systems while utilizing them.

By using University-owned or operated information systems, users assume personal responsibility for their appropriate use and agree to comply with this policy and other applicable University policies. This may also include U.S. federal or State of Texas laws or regulations and University of Texas System policies. See [HOP Policy 5.8.10, Acceptable Use of Information Resources](#)ⁱ for details. Additional policies may be found on the University's policy [website](#)ⁱⁱ.

The University reserves authorization to monitor all activity that ensures compliance with these laws, regulations and policies. Users have no reasonable expectation of privacy. Inappropriate use of University-owned or operated information systems may result in loss of access, disciplinary action or civil or criminal prosecution.

NON-DISCLOSURE: Users must take all necessary precautions to protect proprietary or sensitive University-related information, and to prevent the unauthorized disclosure of that information. Such information must not be used for your own benefit, nor be made available to any person or other organization without authorization, except as required to perform normal functional responsibilities or as required by law.

The user acknowledges the following:

1. I have reviewed, understand and will adhere to information included in the Information Security Awareness briefing that was provided by my sponsor at the University of Texas Health Science Center San Antonio.
2. I have read the University's policies and understand my responsibilities as an authorized user when accessing and using Health Science Center information systems.
3. I agree to adhere to the aforementioned policies and I understand that my failure to comply with the policies and return this form signed may result in my temporary or permanent loss of access.

The sponsor acknowledges that they have provided the Information Security Awareness briefing to the user for viewing.

SPONSOR'S INSTRUCTIONS:

Within five (5) business days of receipt, the sponsor will fax a completed and signed copy of this form to **both** offices below:

1. Information Management & Services Client Support Services (IMS-CSS) – Accounts Management Office, Medical Building, Room 4.484.L, Facsimile: (210) 567-3908

and

2. Information Management & Services – Information Security Office (IMS-IS), Medical Building, Room 4.457.L, Facsimile: (210) 567-2204

If the sponsor foresees any circumstances which would prevent the form from being signed within five (5) business days of receipt, the sponsor must call the IMS-CSS at (210) 567-0750 **before** the deadline.

*Please note: Failure to return a signed copy of this form within the allotted time will result in the user's account being **disabled** until a signed copy has been provided to **both** offices listed above.*

USER AND SPONSOR'S INSTRUCTIONS:

Please print first and last name as appeared on the account request form.

User Name: _____

User Signature: _____ Date: _____

Sponsoring Department: _____

Sponsor's Name: _____

Sponsor's Signature: _____ Date: _____

For Internal Use Only	Change Request: CHG # _____ #
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ⁱ <http://www.uthscsa.edu/hop2000/5.8.10.pdf>

ⁱⁱ <http://www.uthscsa.edu/hop2000/5-toc.html>

UHS



**University
Health System**

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 _____

INFORMATION ACCESS REQUEST FORM

PLEASE SUBMIT THIS COVERSHEET WITH ALL ACCESS REQUESTS-BOTH NEW IDS AND UPDATES

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

TODAY'S DATE: _____ START DATE: _____

USER'S NAME: _____
LAST NAME FIRST NAME MIDDLE INITIAL

LAST 4 DIGIT'S OF THE USER'S SSN: _____

DEPARTMENT NAME: _____

NETWORK USER ID: _____

PROVIDER'S TITLE: _____

PHONE/PAGER NUMBER: _____ EXT. _____

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

PROVIDER ID#: _____ State Lic/Permit #: _____
 CMA

MEDICAL-DENTAL STAFF:

DEA#: _____ DPS#: _____ NPI#: _____

PRESCRIPTIVE AUTHORITY: y /n

HOUSESTAFF:

DEA#: AM1472579 _____ DPS#: 10046768 _____

Military Rotator (_____ to _____)

ALLIED HEALTH:

DEA#: _____ DPS#: _____ NPI#: _____
(if appl)

PRESCRIPTIVE AUTHORITY: y /n

AUTHORIZATION: (Professional Staff Services)

PRINT: _____
NAME TITLE

SIGNATURE: _____

Have any questions? Call Data Security at 358-0640. You can scan and email completed access requests to DataSecurityScannedRequests@uhs-sa.com, fax them to 644-0374, or route them to us at MS124-1.
Rev. 09/09

**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 judgements 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): _____



UNIVERSITY HEALTH SYSTEM

Protective Services Registration/Access/ID Form

NEW EMPLOYEE DATA CHANGE MEDICAL STAFF VOLUNTEER

NAME (LAST, FIRST MI)				R/C	
PHOTO ID STATE		DATE OF BIRTH	EMPLOYEE #	UHS	
DEPARTMENT			CREDENTIALS		
POSITION/TITLE			COMPLETED BY		
PARKING PERMIT DATA (Primary Vehicle)					
VEHICLE	YEAR	MAKE	MODEL	COLOR	BODY SYTLE
LICENSE PLATE NUMBER			STATE OF ISSUE	ACCESS CARD #/TYPE	
FACILITY					
HANG TAG ISSUED (#COLOR/TYPE)					
PARKING PERMIT DATA (Secondary Vehicle)					
VEHICLE	YEAR	MAKE	MODEL	COLOR	BODY SYTLE
LICENSE PLATE NUMBER			STATE OF ISSUE		
FACILITY ACCESS LEVELS ASSIGNED					
KEY CONTROL					
SERIES	KEY NUMBER	ISSUE NO.	DATE	IS/RT	
SERIES	KEY NUMBER	ISSUE NO.	DATE	IS/RT	
SERIES	KEY NUMBER	ISSUE NO.	DATE	IS/RT	
SERIES	KEY NUMBER	ISSUE NO.	DATE	IS/RT	
SERIES	KEY NUMBER	ISSUE NO.	DATE	IS/RT	
SERIES	KEY NUMBER	ISSUE NO.	DATE	IS/RT	
SERIES	KEY NUMBER	ISSUE NO.	DATE	IS/RT	
LOCKER CONTROL					
LOCKER NO.	ROOM NO.	UHS PADLOCK (Y/N)	PADLOCK NO.		

I have been informed of my proper parking area and I have received information regarding the Health System's 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 & 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
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The University of Texas Health Science Center at San Antonio

**NOTICE FOR VOLUNTARY DISCLOSURE OF
SOCIAL SECURITY NUMBER**

School of Medicine Resident Rotators

Disclosure of your social security number (SSN) is requested from you in order for the University of Texas Health Science Center at San Antonio (UTHSCSA) to provide accurate information to affiliated hospitals for Medicare reporting. No statute or other authority requires that you disclose your SSN for that purpose. Failure to provide your SSN, however, may result in your being denied the opportunity to complete clinical rotations. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable laws.

NOTICE ABOUT INFORMATION LAWS AND PRACTICES

With few exceptions, you are entitled on your request to be informed about the information the University of Texas Health Science Center at San Antonio collects about you. Under Sections 552.021 and 552.023 of the *Texas Government Code*, you are entitled to receive and review the information. Under Section 559.004 of the *Texas Government Code*, you are entitled to have The University of Texas Health Science Center at San Antonio correct information about you that is held by The University of Texas Health Science Center at San Antonio and is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that The University of Texas Health Science Center at San Antonio collects will be retained and maintained as required by Texas records retention laws (Section 441.180 et seq. of the *Texas Government Code*) and rules. Different types of information are kept for different periods of time.

You may send any requests to:
The Office of the Vice President/Chief Financial Officer
By mail to: 7703 Floyd Curl Drive, San Antonio, TX 78229-3900
By e-mail to: PublicInfo@uthscsa.edu
By fax to: (210) 567-7027
In person at: Academic and Administration Building, Room 442

CONSENT FOR RELEASE

I **consent** for the release of my social security number for the stated purposes above.

Print Name: _____

Signature: _____

Date: _____

Please return form to
Graduate Medical Education * 7703 Floyd Curl Drive MC 7790 * San Antonio, Texas 78229-3900

Confidentiality/Security Acknowledgement

The University of Texas Health Science Center at San Antonio (UTHSCSA) has a legal and ethical responsibility to safeguard the privacy of all patients and protect confidentiality and security of all health information. During your employment or affiliation with UTHSCSA you may hear information related to a patient's health or read or see computer or paper files containing confidential health information, whether or not you are directly involved in providing patient services. You may also create documents containing confidential patient information, if it is part of your job description and/or as directed to do so by your supervisor.

As part of your employment or affiliation with UTHSCSA, you must strictly adhere to the following regarding confidentiality and security of patient information:

- ✓ *Confidential Health Information.* I will regard patient confidentiality as a central obligation of patient care. I understand that all information, which in any way may identify a patient or which relates to a patient's health, must be maintained in the strictest confidence. Except as permitted by this Acknowledgement, I will not at any time during or after my employment or affiliation speak about or share any patient information with any person or permit any person to examine or make copies of any patient reports or other documents that I come into contact with or which I create, except as allowed within my job duties or by patient authorization.
- ✓ *Permitted Use of Patient Information.* I understand that I may use and disclose confidential patient information only to other providers of health care services, if the purpose of the disclosure is for treatment, consultation, or referral of the patient. If my job description allows, I may also disclose information for payment and billing purposes and/or internal operations, such as use for internal quality studies and for internal education activities.
- ✓ *Prohibited Use and Disclosure.* I understand that I must not access, use or disclose any patient information for any purpose other than stated in this Acknowledgement. I may not release patient records to outside parties except with the written authorization of the patient, the patient's representative, or for other limited or emergency circumstances. Special protections apply to mental health records, records of drug and alcohol treatment, and HIV related information. I must neither physically remove records containing patient information from the provider's office, clinic, or facility, nor alter or destroy such records. Personnel who have access to patient records must preserve their confidentiality and integrity, and no one is permitted access to health information without a legitimate, work-related reason.

I also agree to immediately report to my supervisor or to the UTHSCSA Privacy Officer any non-permitted disclosure of confidential patient information that I make by accident or in error. I agree to report any use or disclosure of

confidential patient information that I see or know of others making that may be a wrongful disclosure.

- ✓ *Safeguards.* In the course of my employment or affiliation if I must discuss patient information with other healthcare practitioners in the course of my employment or affiliation, I will use discretion to ensure that others who are not involved in the patient's care cannot overhear such conversations. I understand that when confidential patient information is within my control, I must use all reasonable means to prevent it from being disclosed to others except as permitted by this Acknowledgement.

Protecting the confidentiality of patient information means protecting it from unauthorized use or disclosure in any format, oral/verbal, fax, written, or electronic/computer.

- ✓ *Computer Security.* If I keep any identifiable patient information on a personal digital assistant (PDA), laptop, or other electronic device, I will ensure that my supervisor knows I am using it and has approved such use. I agree not to send patient information in an e-mail unless my supervisor directs me to do so in an emergency. I will not attempt to access information by using a user identification code or password other than my own, nor will I release my user identification code or password code to anyone, or allow anyone to access or alter information under my identity. I will ensure that my virus protection software is updated on a routine basis (once per week) and that I back up any confidential information using approved back up procedures.
- ✓ *Physical Security.* I will take all reasonable precautions to safeguard *confidential* information. These precautions include using lockable file cabinets, locking office doors, securing data disks, tapes or CDs, using a password protected screen saver, etc. I agree to store my electronic media in recommended containers and store back up media in approved locations.
- ✓ *Return or Destruction of Information.* If my employment or affiliation with UTHSCSA requires that I take patient information off the UTHSCSA campus or off the property of UTHSCSA affiliates, I will ensure that I have UTHSCSA's or the other facility's permission to do so. I will protect patient information from unauthorized disclosure to others, and I will ensure that all patient information is returned to the appropriate facility.

Unless specifically stated in my job description, I am not authorized to destroy any type of original patient information maintained in any medium, i.e., paper, electronic, etc.

- ✓ *Termination.* When I leave my employment or affiliation or complete my training or residency at UTHSCSA, I will ensure that I take no identifiable patient information with me, and I will return all patient information in any format to the

UTHSCSA or other appropriate facility. If it is not original documents, but rather my own personal notes, I must ensure that such information is destroyed in a manner that renders it unreadable and unusable by anyone. Discharge or termination, whether voluntary or not, shall not affect my ongoing obligation to safeguard the confidentiality and security of patient information and to return or destroy any such information in my possession.

- ✓ *Violations.* I understand that violation of this Acknowledgement may result in corrective action, up to and including termination of my employment or affiliation. In addition, violation of privacy or security regulations could also result in fines or jail time.
- ✓ *Disclosures Required by Law.* I understand that I am required by law to report suspected child or elder abuse to the appropriate authority. I agree to cooperate with any investigation by the Department of Health and Human Services or any oversight agency, such as to help them determine if UTHSCSA is complying with federal or state privacy laws.

I understand that nothing in this Acknowledgement prevents me from making a disclosure of confidential patient information if I am required by law to make such a disclosure.

I understand that if I believe in good faith that UTHSCSA has engaged in conduct that is unlawful or otherwise violates clinical or professional standards, or that the care, services, or conditions provided by the UTHSCSA potentially endangers one or more patients, workers, or the public, a disclosure of confidential information may be made, but only to the appropriate public authority and/or to the attorney retained by me for the purpose of determining legal options with regard to the suspected misconduct.

My signature, on the following page, acknowledges that I have read the terms and conditions of this Acknowledgement. The signature page will be maintained by my department supervisor.

NOTE: To access specific policies regarding privacy or security issues, please refer to the *Handbook of Operating Procedures (HOP)*, available at <http://www.uthscsa.edu/hop2000/>. Security policies are located in Chapter 5 and privacy policies in Chapter 11.

Confidentiality/Security Acknowledgement Signature Page

By my signature below, I acknowledge that I have read the terms and conditions of the Confidentiality/Security Acknowledgement. I am maintaining the three page Acknowledgement for my own records.

Signature: _____
Please circle *UTHSCSA Employee Resident/Intern Student Non-employee*

Printed name: _____

Date: _____

Work Phone: _____

Department: _____

V A

The University of Texas Health Science Center - School of Medicine - Windows Internet Explorer

http://www.uthscsa.edu/GME/incomingresidents.asp

Step Three: Complete These Hospital/UT Forms

VA Hospital (STVHCS) Forms

1. [Resident Welcome Letter](#)
2. [VA Resident Application](#) (all incoming and switching specialties need to complete this)
3. [OF306](#) (please complete and sign both 17A and 17B on second page)
4. [I-9](#)
5. [PIV Sponsor Register Checklist](#) (complete and return asap to start badge processing)
6. [Forms of ID for PIV](#) (choose 2 of these to present when you are fingerprinted)
7. [Courtesy Fingerprint Memo](#) (for Housestaff being fingerprinted at a VA outside of San Antonio)
8. [Mandatory Training Modules](#) (content information only; do not return)
9. [Mandatory Training Exams](#) (exams only; please return)
10. [VA Clinical Trainee Worksheet](#) (fill out with current address and return)
11. [CPRS Training and Quiz](#) (fill out quiz and return)

Please email all forms to:
marleen.mueller@va.gov

You will be able to sign all documents at processing.

If you cannot email, please print out and mail to:
South Texas Veterans Health Care System
7400 Merton Minter Blvd.
San Antonio TX 78231
ATTN: Marleen Mueller (14A)

start | 3 Microsoft Offi... | 5 Microsoft Offi... | Hill | The University of ... | Search Desktop | Internet | 100% | 3:59 PM

Mandatory documents that Military (non-integrated) Residents Rotators need to complete if they are required to complete any portion of their training at the VA Hospital.