MultiCare
Graduate Medical Education

MHS INW GME Required Documentation for Onboarding Visiting Residents

Resident Documentation Requirements and Program Coordinator Attestation

Prior to completing documentation, please view the Standards of Business Conduct Handbook. Go to https://www.multicare.org/for-employees/graduate-medical-education-gme/graduate-medical-education-inw/documentation/ and click on "Standards of Business Conduct".

Please review and sign the forms listed below. Your residency coordinator will collect your documents and submit them for review and processing.

- MultiCare Health System INW GME Intake Form
- MHS Confidentiality and Use Statement
- HIPAA Confidentiality Statement
- MHS Standards for Business Conduct
- Resident Acknowledgment
- Code of Conduct Acknowledgment
- Independent Contractor Confidentiality Agreement
- Blood-Borne Pathogens Disclosure Statement
- Workforce Information Security Agreement
- Resident Background Policy and Consent Form with Consent, Disclosure, and Release
- Substance Policy and Consent Form with Student Consent, Disclosure, and Release
- Attestation to Proficiency with EPIC Fundamentals
- Proof of Flu Vaccine for current season (Oct 1 - April 30)
- Copy of COVID Vaccine Card (*front and back - no cell phone shots, please*) This requirement begins **Oct 18, 2021**. Residents must be fully vaccinated *(number of vaccinations dependent upon brand of vaccine)*

For Residency Coordinator -*Please complete the following:*

I, _____ (*Residency Coordinator*), from _____ (*Residency Program)*, attest that the following items are on file for _____ (*Resident name*) and will be available upon request by MultiCare Health System GME office.
Date: _____

- A current certificate of insurance for the residency
- National Criminal Background Check, complete as of enrollment in the residency
- WA State Patrol WATCH Report, complete as of enrollment in the residency
- 5-panel (*minimum*) drug screening, complete as of enrollment in residency
- Established immunity for:
  - Measles, Mumps, Rubella
  - Varicella *(Chicken Pox)*
  - Hep B *(titer or signed waiver)*
  - TB *(record of test administered as of enrollment in residency*)

**** END OF REQUIREMENTS ****

MultiCare
Graduate Medical Education

MultiCare Health System INW GME Intake Form

This form is to be completed after review of MultiCare Policies and must be completed and processed through the appropriate MHS Support Departments prior to client obtaining access to MultiCare systems.

Return this form with all required documentation to angela.larson@multicare.org

Visiting Resident: *(Please circle one)* **MD** **DO**

NPI#_____

Have you ever: (Answer yes or no for each question)

Had a background check completed? _____
Been employed by MultiCare Health System? _____
Volunteered for MultiCare Health System? _____
Been a former student or resident? _____

User Information: ***(Please use your legal name)***

Last Name: _____ Legal First Name: _____ MI: _____
Former Names: _____ Job Title/Role: _____
Last 4 of Soc Sec#: _____ Birthday = MM/DD/YYYY: _____
Personal Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Phone: _____ Work Phone: _____

Residency Program: ***(Your residency coordinator's information must be included here)***

Residency Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Coordinator's Name: _____Coordinator's Email: _____
Coordinator's Phone: _____Coordinator's FAX: _____

Rotation Location(s): ***(INW - Spokane locations are in bold print)*** ***Please circle anticipated work location(s):***

Allenmore Hospital
Auburn Medical Center
Covington Medical Center
Deaconess Hospital
Good Samaritan Hospital
Immediate Clinic
Indigo Urgent Care (Not Available in Spokane)
Rockwood Clinic
Spokane Internal Medicine
Tacoma General Hospital
Valley Hospital

MMA Clinic, please list: _____
Other, please list: _____
Specific Department/Unit within Location(s): _____

MHS Sponsor: Angie Larson Email: angela.larson@multicare.org Phone: 509-473-7295

All trainees are expected to meet with their supervising physician or provider prior to procedures. The purpose of this is to have the trainee communicate to the supervisor their stage of training/education, their familiarity with the planned procedure, and focus areas where they would like feedback. There should also be a discussion regarding the role of the trainee in the procedure.

USER SIGNATURE: _____ DATE: _____

MultiCare
Graduate Medical Education

MHS Confidentiality & Use Statement

I understand that MultiCare Health System ("MHS") Information Services ("IS") provides a wide range of services and support to physicians and other healthcare providers, and their support staffs, within its service area, including the provision of practice management tools and access to electronic medical records and patient accounting systems.

I acknowledge that MHS maintains patient records and information in a confidential manner. Information in patient records or information collected from the patient is kept in strict confidence in accordance with the Uniform Health Care Information Act, the Health Insurance Portability & Accountability Act, and other state and federal laws. Systems for the privacy and security of patient records have been developed and are an important part of protecting patient confidentiality.

During the normal course of my duties at MHS, I may have access to confidential patient records, protected health information (PHI), Personally Identifiable Information (PII), sensitive business information and other types of information that must be kept in confidence by me. This information may be maintained by MHS within one or more Application(s) or System(s), for the purpose of providing treatment to my patients, business operations and other reasonable business practices. By having access to such information, I agree to abide by all MHS policies and procedures pertaining to access and use of MHS Application / System records. I understand such policies and procedures may change from time to time, and I agree to participate in appropriate Application / System user education and training on an ongoing basis, and to familiarize myself with all applicable MHS policies and procedures.

I have reviewed the MHS policies and procedures regarding patient confidentiality and information security. As a condition of my access to and use of information maintained within MHS Application(s) / System(s), I agree to abide by all established MHS policies relating to patient confidentiality. I will not access patient records or information via hard copy or information system unless I have a "need to know" in order to provide medical care and treatment to my patients.

I understand that entries in patient records within MHS Application(s) / System(s) are accessible by other health care providers, and once entered become part of the patient's composite health record within MHS and cannot be removed or segregated from other records within MHS applicable to such individual patients, particularly with regard to any MHS Patient Care Information System(s).

I understand that unauthorized use or disclosure of PHI, PII or other sensitive information may subject me to civil liability under state and/or federal law, and that improper disclosure may also constitute a crime. I understand and authorize MHS to monitor and audit my use and access of all MHS Application(s) / System(s).

I agree to use and access PHI, PII and other sensitive information strictly for lawful purposes within the scope of my duties and responsibilities and for no other purpose. I accept responsibility for taking appropriate measures to secure my workstation. I also agree to keep my MHS Network System password(s) private and not share password(s) with others.

I assure MHS that I will not, under any circumstances, use or disclose PHI, PII or other sensitive information for any unauthorized purpose, and I will take appropriate steps to protect the confidentiality of patient information and records.

I will immediately report to the MHS Information Services Help Desk any observed or known violations of this user agreement by myself or others having access to MHS Applications or Systems.

I understand that unauthorized use or disclosure of PHI, PII or other sensitive information constitutes a violation of my employment or my clinic's or department's agreement with MHS allowing access to MHS Application(s) or System(s), and that willful violation of MHS rules may result in termination of my access or my clinic's or department's rights to utilize MHS Application(s) or System(s).

I have read and understand the above statements.

_____
User Name (Please Print)

_____ _____
User Signature Witness Name (Please Print)

_____ _____
Date Witness Signature

☐ Electronic-Signature Only: By providing my e-signature, I understand that checking this box constitutes my legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document and is the equivalent and has the same force and effect of my wet (handwritten) signature.

MultiCare

Graduate Medical Education

HIPAA Confidentiality Statement

MultiCare Health System maintains patient records and information in a confidential manner. Information in patient records or information collected from the patient is kept in strict confidence in accordance with the Uniform Health Care Information Act. Systems for the security of patient records have been developed and are an important part of protecting patient confidentiality.

I have reviewed the MultiCare policies and procedures regarding patient confidentiality. I agree to abide by all established MultiCare policies relating to patient confidentiality. I will not access patient records or information via hard copy or information system unless I have a "need to know," in order to perform my student/resident related responsibilities. I assure MultiCare Health System that I will take appropriate steps to protect the confidentiality of patient information and records.

I understand that unauthorized use or disclosure of patient information may subject me to civil liability under Washington state law. I have read and understand the above statement.

_____

Name (Please Print)

_____ _____

Signature Date

I have had HIPAA education through my residency program:

_____

Name of Residency

MHS STANDARDS FOR BUSINESS CONDUCT

To view the Standards of Business Conduct Handbook, please go to https://www.multicare.org/for-employees/graduate-medical-education-gme/graduate-medical-education-inw/documentation/ and click on "Standards of Business Conduct".

Ethical Business Practices

Business practices must be conducted with integrity, honesty and fairness. These qualities are demonstrated through truthfulness, the absence of deception or fraud, and respect for the laws applicable to our business. Your signature below indicates that you agree to conduct your business in an ethical manner; that you will not lie or seek to deceive; you will not bribe or otherwise induce any employee to enter into a business agreement with you. You agree not to speak badly of your competition or discredit their products or employees and you will negotiate in good faith. You agree to follow the policies set forth in the Standards of Business Conduct Handbook and maintain patient confidentiality in all of your interactions.

Conflicts of Interest

A conflict of interest occurs if an outside interest or activity may influence or appear to influence an employee's ability to exercise objectivity or meet their job responsibilities for MultiCare Health System. MultiCare Health System employees and their families are prohibited from receiving gifts, loans, entertainment or any other consideration of value from a person or organization that does business or may want to do business with MultiCare. The only exception is a gift of nominal value extended as business courtesy, such as sales promotion items or occasional business-related meals or entertainment of modest value.

Code of Conduct

- Obey the applicable laws and regulations governing our business conduct, including billing for services.
- Be honest, fair, and trustworthy in all activities and relationships.
- Do not lie, cheat, bribe or steal
- Conduct your business in an ethical manner
- Avoid all conflicts of interest between work and personal affairs.
- Keep business transactions free from offers or solicitation of gifts and favors, or other improper inducements

My signature on this form acknowledges that I have received and read the MultiCare Health System Standards for Business Conduct. I agree to comply fully with the standards contained herein. I understand that compliance with these standards is a condition of my continued association with MultiCare Health System. I also understand that MultiCare Health System reserves the right to occasionally amend, modify and update the Standards for Business Conduct.

Print Name

Signature

Date

MultiCare
Graduate Medical Education

Resident Acknowledgment

The undersigned resident ("Resident") hereby acknowledges that he or she is a resident in the _____ program (the "Program") at _____. As a condition of the Resident's participation in the Program, including observational or practical experience at MultiCare Health System ("MHS"), Resident agrees to the following:

1. Resident shall adhere to the internal policies of MHS including but not limited to those related to work place safety, dress, and compliance issues. Without limiting the generality of the foregoing, Resident agrees to protect and maintain the confidentiality of any and all patient information that Resident may come into contact with while participating in the Program. Resident shall comply with all state and federal laws regarding patient information, including but not limited to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and any MHS policies and procedures related to such laws. Resident understands that he or she may be removed from the program immediately for failure to follow MHS policies.

2. Resident understands and agrees that any and all injuries sustained while functioning in the formal role of Resident may be treated by the MHS in accordance with MHS policy. However, it is further understood that any and all charges resulting from this treatment remain the sole responsibility of the Resident.

3. Resident understands and agrees that he / she is not entitled to wages for activities which are related to the education and training received at MHS. Further, Resident understands and agrees that she / he is not entitled to workers' compensation benefits for any injury sustained during an education placement.

_____ _____

Signature of Resident Residency

_____

Date

First start date at MHS: _____

Last end date at MHS: _____

MultiCare
Graduate Medical Education

ATTESTATION TO PROFICIENCY WITH BASIC FUNCTIONS OF THE

EPIC EMR SYSTEM

I, _____

(Circle One): **MD** **DO**

do hereby attest that I have recent experience using an EPIC-based electronic health record (EHR) as a resident physician. I additionally attest that I am competent in the basics of navigating and interacting with the standard EPIC workspace. I am confident that my current knowledge, training, and experience has prepared me well to provide basic patient care, and to learn and then utilize the unique aspects of MultiCare Health System's instance of EPIC.

With this attestation in mind, I am formally requesting to bypass the EPIC Provider Fundamentals course. I ***understand that I will be registered for subsequent, mandatory, Provider level specialty training prior to, or as close as possible to, the beginning of my rotation.***

_____ _____

Name (Please print) Date

_____

Signature

*****SUBMIT COMPLETED FORMS TO*****
INW Provider Services Office
Attn: GME Office
Deaconess Medical Office Building
800 W. Fifth Avenue
Suite 304
Spokane, WA 99204
Email: angela.larson@multicare.org
FAX: 509-473-3687

MultiCare
Graduate Medical Education

Towne Park – Parking Agreement

PROVIDER INFORMATION:

Name: _____ Specialty: **Resident Provider**

Group Name: Spokane Teaching Health Center Email: _____

Cell Phone: _____ Work Phone: _____

Address: 624 E. Front Ave City, State: Spokane, WA 99202

1st Vehicle

Vehicle Information:

Plate/State: _____

Make: _____

Model: _____

Year and Color: _____

2nd Vehicle

Vehicle Information:

Plate/State: _____

Make: _____

Model: _____

Year and Color: _____

GME Specialist will complete below

RED TAG # _____ **PROXY #** _____