MultiCare
Graduate Medical Education

INW MHS GME Required Documentation for On-boarding Medical Students, Nurse Practitioner Students, CNM Students, and Physician Assistant Students

Important information for School and Student:

- **Submit all required documentation to the GME office no less than thirty (30) days prior to student's start date**
- **Submit documentation in one file via email to angela.larson@multicare.org**
- **Include Student Name, School, Clinical Location, Preceptor Name, Start and End Date on Subject Line of Email**

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".

Sign and Return the following items in one file:

- MultiCare Health System INW GME Intake Form
- MHS Confidentiality and Use Statement
- HIPAA Confidentiality Statement
- MHS Standards for Business Conduct
- Student Acknowledgment
- Code of Conduct Acknowledgment
- Independent Contractor Confidentiality Agreement
- Blood-Borne Pathogens Disclosure Statement
- Workforce Information Security Agreement
- Student Background Policy and Consent form with Student Consent, Disclosure, and Release
- Student Substance Policy and Consent Form with Student Consent, Disclosure, and Release
- Attestation to Proficiency with EPIC Fundamentals

Additional Documentation:

- Letter of Good Standing
- .JPEG photo (head and shoulders - no selfies), suitable for use on a badge
- 5-panel drug screen (current as of time of enrollment in program of studies **OR** later) including: (***Note:*** A typical 5-panel drug screen will test for the following):

Amphetamines	*THC*	*Cocaine*
Methamphetamine	*Opiates*	

- National Criminal Background Screening (current as of time of enrollment in program of studies **OR** later - report should be available from your program coordinator)
- Washington State Patrol WATCH Background Check (current as of time of enrollment in program of studies **OR** later - report should be available from your program coordinator) May be obtained from https://fortress.wa.gov/wsp/watch/ *(select "Name and Date of Birth option)*

Proof of immunity established for:

- Measles, Mumps, Rubella
- Varicella (Chicken Pox)
- Hep B (titer or signed waiver)
- Pertussis (TDaP)
- TB (baseline test administered at time of enrollment in program of studies is acceptable)
- Flu Vaccination (required during Oct 1 - April 30 flu season)
- Copy of COVID Vaccine Card (front and back) *This requirement begins October 18, 2021. Students must be fully vaccinated (number of vaccinations dependent on brand)*

*** END OF REQUIREMENTS***

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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 as one attachment, all three pages, to angela.larson@multicare.org

Students: ***Medical Student*** ***PA Student*** ***NP Student*** ***Midwifery Student***

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 ? _____

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: _____

School Information: *(Your school and program coordinator's information must be included here.)*

School 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: _____

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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 school program:

_____

Name of School

MHS STANDARDS FOR 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.

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".

Name (Please Print Legibly)

Signature

Date

MultiCare
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Student Acknowledgment

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

1. Student 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, Student agrees to protect and maintain the confidentiality of any and all patient information that Student may come into contact with while participating in the Program. Student 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. Student understands that he or she may be removed from the program immediately for failure to follow MHS policies.

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

3. Student 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, Student understands and agrees that she / he is not entitled to workers' compensation benefits for any injury sustained during an education placement.

_____ _____

Signature of Student School and Program

_____

Date

First start date at MHS: _____

Last end date at MHS: _____

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Acknowledgment - MultiCare Code of Conduct

I acknowledge that I have received, read and understand the MultiCare Code of Conduct

I agree to abide by the policies summarized in the Code of Conduct and all federal, state and local laws, rules and regulations for the duration of my association with MultiCare

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Signature

Printed Name

Date

MultiCare: Deaconess Hospital, Valley Hospital, Rockwood Clinic(s)

MultiCare

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Independent Contractor
Confidentiality Agreement

I, _____, recognize and acknowledge that in the performance of my services at MultiCare: Deaconess Hospital, Valley Hospital, Rockwood Clinic(s) as an independent contractor, as an employee of a staffing agency, or as a student, I will be working with and have access to certain Confidential Information. Confidential Information includes but is not limited to, information disclosed to me or known by me as a result of my association with the facilities and the services I provide to the facilities and information about the facility's operations and other matters (whether or not such information constitutes a trade secret) that are of a confidential or proprietary nature, including and related to, but not limited to, patient background information, medical records or other medical information, diagnostic reports, facilities organizational information, clinical information, computer data, and financial information in whatever form such information may exist including any charts, records, manuals, data, computer data, notes, drawings, graph, analysis, and related materials.

I agree to keep all such Confidential Information in strict confidence and will not at any time, during or after the performance of services for the facilities, disclose or disseminate any Confidential Information that I may be provided or have access to as a result of my association with the facilities and the services provided to it to any third party except in connection with and as necessary to the performance of my services for the facilities and with any further patient consent as may be required. Specifically, but without limiting the foregoing, I agree not to disclose any Confidential Information to persons not authorized by the facilities, and I further agree that Confidential Information must not be disclosed to competitors, suppliers, contractors, family members, or facilities. I also agree not to reproduce, transmit, transcribe, or remove from the premises of the facilities any Confidential Information except in connection with and as necessary to the performance of my services for the facilities. Furthermore, I agree not to use any Confidential Information for my personal gain or for that of persons not affiliated with the facilities.

I understand and agree that I am obligated to maintain patient confidentiality at all times whether or not such patient confidentiality involves Confidential Information. I understand that it is not permissible to discuss patient-related Confidential Information in public places or with persons that have no reason to know the patients' medical care or treatment.

I understand and agree that any and all computer system access codes and passwords that are assigned to me are confidential. I will not disclose any such codes or passwords to anyone other than as necessary in connection with the services I provide to the facilities. If I have reason to believe that the confidentiality of such codes or passwords has been violated. I will contact the MIS Department of the facilities immediately upon termination of my independent contractor relationship; I understand that any an all codes and passwords that have been assigned to me will be deleted from the appropriate system(s) and that I will have no right or interest in any data related thereto. Notwithstanding the terms of this Confidentiality Agreement, I understand and agree that I have no personal expectation of privacy with respect to any Confidential Information.

My signature below certifies that all of the above confidentiality requirements have been explained to me, that I was afforded the opportunity to ask questions about such requirements, and that I agree to be bound by the terms of this Confidentiality Agreement.

_____ _____

Name (Please Print) Date

_____

Signature

MultiCare

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Blood –Borne Pathogens
Disclosure Statement

DOSH Blood-Borne Pathogen Standards
I certify that my job code has been identified as either: (Check one)

☐ Category I May have exposure to blood-borne pathogens during performance of my job.

☐ Category II No exposure to blood-borne pathogens is expected during the performance of my job.

Note:

These pathogens include, but are not limited to, Hepatitis B Virus (HBV) and HIV virus.

_____ _____

Name (Please Print) Date

_____

Signature

Workforce Information Security Agreement

I understand that the facility or business entity (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity for which I work as a relationship (contractual or otherwise) involving the exchange of health information, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Company, I understand that I may come into contact with this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Privacy and Security Policies, which are available on the Company intranet. **I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.**

1. I will act in the best interest of the Company and in accordance with its policies, procedures and Code of Conduct at all times during my relationship with the Company.
2. I understand that I should have no expectation of privacy when using Company information system. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that I have no right to any ownership interest in relationship with the Company.
4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated password appropriately, and position screens away from public view.
5. I will only access or use system or devices I am officially authorized to access, and will not demonstrate the operation of function of systems or devices to unauthorized individuals.
6. I will:
    a. Use only my officially assigned user ID, password, etc.
    b. Use only approved licensed software
    c. Use devices with virus protection software
    d. Report theft or loss of mobile devices (cell phones, PDAs, laptops, etc.) that store Confidential Information within 24 hrs.
7. I will never:
    a. Share or disclose user IDs or passwords, nor will I ask others to do so
    b. Use tools or techniques to break or exploit security measures
    c. Connect to unauthorized networks through the Company's system or devices
    d. Knowingly include, or cause to be included, any false, inaccurate or misleading entry in any record or report
8. I will not disclose or discus any Confidential Information with others, including friends or family, who do not have a need to know
9. I will not in any way copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
10. I will not make unauthorized transmissions, inquiries, modifications, or purging of Confidential Information
11. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
12. I will only access electronic system to review patient records for which my job responsibilities have a legitimate need to access for treatment, payment or healthcare operations.
13. I will notify my manager or appropriate Information Services person if my password has been sent, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
14. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
15. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
16. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and /or termination of authorization to work within the Company, in accordance with the Company's policies.

The following statement apply to physicians and contracted entities using Company systems containing patient identifiable health information:

1. I will insure that only appropriate personnel in my office will access the Company's electronic systems, and I will annually train such personnel on issues related to patient confidentiality and access.
2. I will accept full responsibility for the actions of my employees who may access the Company's electronic systems and Confidential Information.

I acknowledge that I have read this Agreement and I agree to comply with the terms and conditions stated above.

Name (Please Print)	Date
Signature	MultiCare: Deaconess Hospital, Valley Hospital Rockwood Clinic(s) Facility

Student Background Policy and Consent Form

Name of School:
Name of Facilities: MultiCare: Deaconess Hospital, Valley Hospital, Rockwood Clinic(s)

Facility policy requires Student (as well as applicants, employees and contractors) to pass background checks before being allowed to access the Facility.

The Background Check Policy

The Students are seeking Facility experience that is not granted to the general public.

By choosing to access the Facility through a clinical rotation, the Student must agree to have a background check as described in the Student Affiliation Agreement and herein.

Any Student who has chosen not to agree to this policy has chosen not to be in a clinical rotation at the Facility.

No Student shall be in the program who:

- Has chosen not to comply with Facility's or School's directives;
- Is unfit for duty; and/or
- Has not passed a background check prior to enrollment in their current medical training program.

School shall complete each of the following background checks before Student may provide Patient Care Services at the Facility:

- Office of Inspector General ("OIG") List of Excluded Individuals/Entities
    - Facility shall not accept Students who have been suspended or disbarred from any applicable federal payer program. School uses Certiphi to determine whether Students have been suspended or disbarred from any such program. Certiphi in turn uses an OIG/EPLS search that includes both the HHS OIG LEIE and GSA's EPLS, as well as a SanctionBase Search for administrative and disciplinary actions from sources including: the Food and Drug Administration, Public Health Service, Office of Research Integrity (ORI), and others
- License or Certification
    - Facility shall not accept Students whose licenses or certifications are known or reasonably should be known to have ever been suspended, revoked, terminated, or otherwise modified as to right and privileges. However, if such sanctions resulted from use of a controlled substance and Students have successfully completed a rehabilitation program, Facility may accept them so long as they undergo periodic substance abuse testing as determined by the Facility
- Criminal Records Check
    - School shall conduct criminal records checks on Students through a standard National Background Check (which covers previous seven (7) years) as well as a standard Washington State Patrol request for criminal history information pursuant to RCW 43.43.830-835, as fully described in the Student Affiliation Agreement, before Student may be allowed to provide Patient Care Services at the Facility and thereafter as often as is required by law.

Student Consent, Disclosure and Release

- The information I have disclosed to the school is true, correct and complete. I understand that any misrepresentation, falsification, omission or deception of material facts may cause my application to be rejected or any program participation terminated.
- I authorize the procurement and release of criminal background, federal exclusion, and professional licensure and certification information about me.
- I authorize any entities and individuals with which I have been associated to supply the School and it's agents with this background information, and I release any entities and individuals from all liability whatsoever related to the information or its furnishing.
- I also authorize the School and its agents to contact any government and private entities and persons to verify the validity of any documentation

Student Choice to Consent or Not Consent

I have read the above and I choose to (check one)

☐ Consent

OR

☐ Not consent (not remain or be in a clinical rotation at the Facility)

Student and Witness Signatures

Student Section	**Witness Section**
Print Name	Print Name
Signature	Signature
Date	Date

Additional Consent for Student under the Age of 18

As the parent and/or guardian of the Student named above, I hereby consent to and authorize the School and Facility and affiliated persons and/or entities to proceed as outlined above.

Name (Please Print)	Date
Signature	Student Name

Student Substance Policy and Consent Form

Name of School:
Name of Facilities: MultiCare: Deaconess Hospital, Valley Hospital, Rockwood Clinic(s)

Facility policy prohibits Students (as well as applicants, employees and contractors) from using "substances" including, but not limited to, illegal drugs and legal prescription drugs without a current, legal and valid prescription. Alcohol may not be used in a manner that will cause Student to be impaired while at the Facility. Students shall be tested for Substances as described herein.

The Substance Policy

The Students are seeking Facility experience that is not granted to the general public. It is Facility policy to maintain a drug and alcohol free environment.

By choosing to access the Facility through the program, the Student must agree to follow the Facility's substance abuse policy, including Substance Testing.

Any student who chooses not to agree to this policy has chosen not to be in the program.

No Student shall be in the program who:

- Has chosen not to comply with the Facility's or School's directives;
- Is unfit for duty; and/or
- Has not passed a Substance prior to enrollment in their current medical training program.

The School Shall:

- Inform each Student that Facility requires him/her to complete a Student Substance Policy Consent From;
- Provide the Facility with a copy of each Student's completed Consent Form or request Student to provide the completed Consent from the Facility;
- Conduct testing of Students through a licensed laboratory, including when a Student has been absent from the School or program for more than (30) days (except for regularly calendared breaks) and there is reasonable cause to believe that Substance induced impairment is involved; and
- Provide Facility with documentation of Student's 5-panel (minimum) laboratory test results dated on or about time of enrollment **OR** later in current training program, or since that date.

Testing may also be required by the Facility:

- When a Student is injured at the Facility and Facility has reasonable cause to believe that such Substance induced impairment is involved;
- When a drug is not accounted for per Facility policy and Facility has reasonable cause to believe that the Student may have diverted the drug;
- For oversight of a Student who has previously completed a drug rehabilitation program;
- When a Student appears to be unfit for duty and Facility has reasonable cause to believe that Substance induced impairment is involved.

Student Consent, Disclosure and Release

I choose to:

- Agree with and follow the Substance Policy
- Provide any specimen(s) and authorize the School and/or Facility and any associated persons and/or entities to conduct screening tests for alcohol and drugs as provided in the Substance Policy in the instances described and allow them to access and utilize specimen and test information as needed as provided in the Substance Policy.
- Release the School and the Facility and any associated persons and/or entities from any and all claims, causes of action, damages, or liabilities whatsoever arising out of or related to the Substance Policy and Process.

Student Choice to Consent or Not Consent

I have read the above and I choose to (check one)

☐ Consent

OR

☐ Not consent (not remain or be in the program)

Student and Witness Signatures

Student Section	Witness Section
Print Name	Print Name
Signature	Signature
Date	Date

Additional Consent for Student under the Age of 18

As the parent and/or guardian of the Student named above, I hereby consent to and authorize the School and Facility and affiliated persons and/or entities to proceed as outlined above.

Name (Please Print)	Date
Signature	Student Name

MultiCare
Graduate Medical Education

ATTESTATION TO PROFICIENCY WITH BASIC FUNCTIONS OF THE EPIC EMR SYSTEM

I,_____

(Print Name)

(Circle One): **Medical Student** **PA Student** **Nurse Practitioner Student** **Midwifery Student**

do hereby attest that I have recent experience using an EPIC-based electronic health record (EHR) as a resident physician or student. 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 both 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 be ***exempt from 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