



Graduate Medical Education

Application for Visiting Resident and Medical Student Rotations

APPLICANT INFORMATION

Name (First, Middle, Last): \_\_\_\_\_

Home Street Address: \_\_\_\_\_

Home City, State, Zip Code: \_\_\_\_\_

Email accessible prior to/ during rotation (must be non-military): \_\_\_\_\_

Contact Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth (Mo/Day/Year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: \_\_\_ Male \_\_\_ Female

MEDICAL STUDENTS ONLY: Degree you are obtaining: \_\_\_ M.D. \_\_\_ D.O. Other: \_\_\_\_\_

Year of Medical School \_\_\_ 3rd \_\_\_ 4th Other: \_\_\_\_\_

RESIDENTS ONLY: Lic #: \_\_\_\_\_ Type: \_\_\_\_\_ State issued: \_\_\_\_\_

NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_

EMERGENCY CONTACT (Please notify the Graduate Medical Education Department of any changes)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact phone: \_\_\_\_\_

EDUCATION

Name of School or Program: \_\_\_\_\_

School's Address: \_\_\_\_\_

School's Phone Number: \_\_\_\_\_ Expected Graduation Mo/Yr \_\_\_\_ / \_\_\_\_

School's Program Coordinator or Director: \_\_\_\_\_

ROTATION SCHEDULE AND SUPERVISING PHYSICIAN (if known)

Rotation Specialty: \_\_\_ Internal Medicine \_\_\_ OB/GYN \_\_\_ Pediatrics Other: \_\_\_\_\_

Rotation Dates: Begin (Mo/Day/Year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ to (Mo/Day/Year): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Supervising Physician on Staff (if known): \_\_\_\_\_

APPLICANT'S CERTIFICATION

I hereby certify that the information I submit in the application is complete and correct to the very best of my knowledge. I agree to abide by all hospital policy and procedures.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

Return completed form along with other required documents to: Lynne Caples, email lynne.caples@shhpens.org,

For questions, contact Lynne Caples, (850) 416-1181.

See continuing pages for Confidentiality and Access Agreement, and Electronic Signature Agreement.



**PHYSICIAN / PHYSICIAN OFFICE STAFF CONFIDENTIALITY AGREEMENT REGARDING  
ACCESS TO SACRED HEART HEALTH SYSTEM ELECTRONIC MEDICAL RECORDS**

Sacred Heart Health System (SHHS) is committed to protecting the privacy and security of individual identifiable health information and other protected health information of a confidential nature for the organization. Information pertaining to patients and other sensitive information must be held in strict confidence.

I hereby acknowledge that I have been given access to the electronic medical record (EMR) of SHHS to view and / or print patient information using secured, encrypted user identification / password combination access via the Horizon Mobile Care Rounding and / or Horizon Physician Portal application(s). My User ID will provide access to my patients' EMR, and I understand that this is for use by me only. Any printed information will be in my possession only and used only in treating my patients. I further acknowledge the following:

- (A) Practice shall include any physician (hereafter referred to as "physicians") practicing within the undersigned physician group, who is a member in good standing of SHHS Medical Staff and has privileges approved by SHHS, and all employees (hereafter referred to as "physician authorized representative") authorized by a physician in a said group to have access to the EMR under the terms and conditions of this Agreement.
- (B) The Practice is allowed access to medical records of patients for whom it physicians(s) is (are) the attending, consulting, covering, referring or primary or record. **The Practice agrees NOT to attempt to access any medical records of patients for whom its physician(s) is (are) NOT physician(s) of record.**
- (C) The only individuals who are authorized to have access to the EMR described above are physicians and physician authorized representatives who are employed by the Practice and who have signed this Confidentiality Agreement. The physician authorized representative must be designated by a physician member in the Practice and shall only be entitled to access the EMR while in the employment and under the supervision of the physician practice member for whom the individual is the authorized representative. Access to the EMR is limited to authorized persons with a need to know, to the extent necessary, to perform their patient care related duties.
- (D) The physician and physician authorized representative can access medical records by using a unique User Identification / Password combination that will be assigned to him or her. The Practice understands that when an authorized individual's User Identification / Password combination is used to gain access to an EMR, the User's ID number, time of access, name of the patient and list of items viewed will be recorded. All individual authorized employees who have access to the EMR will be assigned a unique individual User ID / Password combination in order to access medical records. **The Practice will NOT authorize any other individuals to have access to the EMR of for individuals to use a User ID / Password combination NOT specifically assigned to that individual.**
- (E) The computer sign-on unique User ID / Password is the personal code of the physician or physician authorized representative to whom it is assigned.
- (F) The physician and physician authorized representative are responsible for acting in a prudent manner to maintain security of any remote access devices used to access patient information.
- (G) The Practice understands and agrees that they must hold all medical information in confidence and not disseminates any of the accessed information for any purpose other than medical care and authorized insurance and / or financial purposes. The Practice understands that any violation of the confidentiality of medical information by the Practice may result in a violation of State and Federal law and my result in a claim for damages and / or punitive action. The Practice also agrees to review this Agreement on an annual basis with all of its members. Furthermore, the Practice and its physicians and physician authorized representative agree that they have read and understand the content and information contained in this agreement.
- (H) A Physician who is no longer employed by the Practice is considered to have terminated the Agreement. A physician authorized representative who is no longer employed by the practice is considered to have terminated the Agreement. **The Practice agrees to notify SHHS immediately upon the termination of a physician or physician authorized representative who has access to the EMR.**
- (I) **The Physician must also notify SHHS immediately upon any change in employment status and / or Hospital Medical Staff Standing.**
- (J) Any information obtained from the EMR to which the Practice has access is confidential and must not be disclosed to others unless the patient or his / her authorized representative explicitly consents to such disclosure.
- (K) Specific State and Federal requirements regarding protection of alcohol and drug abuse records, mental health records and HIV related information prohibit the Practice from making any further disclosure of these items without specific written consent of the person to whom it pertains, or as otherwise permitted by said laws. A general authorization for the release of medical information is NOT sufficient for these purposes.

My signature below signifies I have read and understood the "Physician / Physician Office Staff Confidentiality Agreement Regarding Access to Sacred Heart Health System Electronic Medical Records" in its entirety. I hereby agree to the obligations as outlined in the Agreement.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_



**COMPUTER GENERATED ELECTRONIC PHYSICIAN/HEALTHCARE PROVIDER SIGNATURE  
Policy**

Sacred Heart Health System utilizes an electronic medical record. All signatures on dictated reports and documents to be signed post discharge are accomplished electronically. To ensure uniform authentication, all reports authenticated via computer generated electronic signature must contain the printed name of the physician reading and/or dictating the report as well as the date and time signed. This method of authentication will be considered a valid original signature provided the practitioner has certified that he/she will not disclose the identification assigned to him/her to any other person or permit another person to use it. If it is determined that an assigned identifier has been misused; the authorized facility official may terminate a physician/healthcare provider's use of his or her identifier. The term "misused" is defined to mean that the physician/healthcare provider has allowed another person or persons to use his or her personally assigned identifier. Any proof of misuse will be documented by the authorized facility official and actions to terminate the use of the physician/healthcare provider identifier may be initiated immediately. Actions may include written notice to the physician/healthcare provider involved, written notice to the Fiscal Intermediary (if required) and written notice to the Quality Management Department.

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**ELECTRONIC SIGNATURE AUTHENTICATION CONFIDENTIALTY AGREEMENT**

I certify that I will not disclose the identification number assigned to me to any other person or permit another person to use it. I agree to follow all procedures as specified in the electronic signature policy. I am requesting Privileges at Pensacola campus only.

I understand that failure to maintain confidentiality as specified in this policy and procedure will result in revocation of my electronic authentication privileges.

Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_