MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS, INC.

Print Form

NON-MCWAH HOUSESTAFF ASSIGNMENT FORM

Listed below is the form that is used to report assignments of Non-MCWAH housestaff to MCWAH institutions. The purpose of the form is to notify the administrator of the receiving hospital of the arrangements for professional liability coverage. This form is also used by the receiving hospital to claim Medicare reimbursement. A MCWAH housestaff time record must be completed and returned to the MCWAH Office at the conclusion of the rotation. The Confidentiality Agreement, Background Information Disclosure (BID) form and Consumer Authorization form must also be completed. The resident must also attach a certificate of professional liability insurance, documentation of health requirements and proof of OSHA Bloodborne Pathogen Training compliance. This form should be signed by the resident's Program Director **and** the MCWAH Program Director. This form (and accompanying forms) should be sent to the MCWAH Office at least **4 weeks prior to the rotation**.

MCWAH will assign a five-digit number to the resident and report that number back to the Program. The resident must use that number after his/her signature when making chart entries at CHW, FMLH or ZVAMC.

SECTION 1 To Be Completed by the Applicant.

Resident Name _____ Social Security # _____

Current Address _____

Phone Number _____ Email _____

Medical School _____ Graduation Date _____

If IMG, ECFMG # _____ Certificate Date _____ Date of Birth _____

Dates of MCWAH Rotation _____ to _____ MCWAH Program _____

NPI # _____ WI License # (if applicable) _____ DEA #: _____

Please list all of your current and previous GME Training in the United States:

Name of Facility _____ Program _____ PG Level(s) _____

Dates of Training _____ to _____

Name of Facility _____ Program _____ PG Level(s) _____

Dates of Training _____ to _____

Additional Info/Training _____

SECTION 2 To Be Completed by the Applicant's Program Director.

I request approval for the above resident to function in your institution for the period noted. I have reviewed his/her credentials and certify them as acceptable. Our hospital will not claim Medicare reimbursement for this rotation. Our home institution will provide the resident with professional liability insurance (PLI) for this rotation.

Submit the following:

- ❑ Malpractice Insurance – PLI Certificate Attached
- ❑ Background Information Disclosure w/Consumer Authorization Form
- ❑ MCWAH Confidentiality Privacy Form

Healthcare Information - Attach Documentation to Verify

- ❑ TB Testing
- ❑ Measles Antibody Titer or 2 MMR Vaccinations
- ❑ Rubella Antibody Titer or 1 MMR Vaccination
- ❑ Chicken Pox or Positive Antibody Titer or 2 Documented Varicella Vaccinations
- ❑ Hepatitis B Vaccine Series or Positive HBSAB Titer
- ❑ Bloodborne Pathogen Training

Signature of Resident's Program Director _____ Date _____

SECTION 3 To Be Completed by MCWAH Program.

Program _____ Hospital of Rotation: ❑ FMLH ❑ CHW ❑ VAMC Other _____

MCWAH Program Director's Signature _____ Date _____

MCWAH ID # Assigned _____

Revised 12/5/2013 BC

SECTION 4 MCWAH Office Only **Last Name** _____

1. Date Complete Documentation Received _____

2. Documentation of the Health Care Screening and OSHA Training.
Documentation of health care screening and OSHA training is sent to MCW Occupational Health for review, approval and tracking.

Requirements	Received by MCWAH	Approved by Occupational Health	Complete
TB Testing			
Measles Antibody Titer or 2 MMR Vaccinations			
Rubella Antibody Titer or 1 MMR Vaccination			
Chicken Pox or Positive Antibody Titer or 2 Documented Varicella Vaccinations			
Hepatitis B Vaccine Series or Positive HBSAB Titer			
Documentation of OSHA Bloodborne Pathogen Training			

3. Additional Forms and Requirements
The following items are required and verified.

Forms	Date Received	Review Completed
Please √ if this person is a Returnee to: ____Non MCWAH ____RIS		
Confidentiality Agreement		
WI Caregiver Background Information Disclosure (BID) Form w/ Authorization Form. **** If a Non- MCWAH rotator is returning to do another rotation at MCWAH, and MCWAH has conducted a Background Check within the last 4 years it is not necessary to repeat the Background Check. Per BC 6/3/13** **Chris**: Enter date BID form was processed in Non Res file in RIS. Enter date Results from WI check came back in Non Res file in RIS. Fill in States to be queried in Non Res file in RIS and below.		
Maria- Out-of-State to be Queried ____ Data entered on _____ Results Rec'd on _____ by ____ Out-of-State to be Queried ____ Data entered on _____ Results Rec'd on _____ by ____		
Certificate of Professional Liability Insurance		
ECFMG Certificate Verified Through CVS Online Service		

4. Program Letter of Agreement Review
All Program Agreements must be reviewed by MCWAH Risk Management prior to being finalized.

1. Parties to the agreement correctly identified.
2. Educational objectives and goals are listed.
3. Site director and faculty who will direct the educational experience identified.

4. Duration of the rotation specified.
5. Sponsors and site's policies and procedures will govern conduct.
6. Sponsor insures their resident/fellow for $1 million per occurrence/$3 million in aggregate.
7. All required signatures obtained by both sponsoring organization and host. MCWAH signature requirements include:
   a. Executive Director/DIO
   b. Program Director

5. Copy to:
Medical Staff Office _____ Program Director _____ MCWAH ID# Assigned _____