HARRISHEALTH SYSTEM

Medical Staff Services Use Only: Provider ID
_____

Medical Staff Services "Trainees" Registration Form

☐ Medical Student ☐ SRNA Student ☐ PA Student ☐Other: _____

☐ Resident ☐ Fellow ☐ PGY _____

Applicable to Residents & Fellows Only:	
TX Permit #: _____ Expiration Date: _____	NPI #: _____
DEA #: _____ Expiration Date: _____	DPS #: _____ Expiration Date: _____

Have you ever worked at any Harris Health System facility prior to this time? ☐ YES ☐ NO

If yes, what was your Harris Health Provider ID#: _____

Medical School Affiliation	☐BCM ☐UTH ☐Other _____
Clinical Specialty _____	Clinical Department _____
Anticipated Program Start Date _____	Anticipated Program Completion Date _____

First Name	Middle Name	Last Name	Suffix
Maiden Name	**Aliases by Which You Have Been Known**		**Marital Status**
Social Security Number	**Date of Birth**		**Gender**

Social Security Number Disclosure Notice (5 U.S.C. §552a Section 7): It is mandatory that you provide your Social Security Number to Harris Health System. Harris Health System does not employ, retain or engage in business relationships with individuals and entities that have been convicted of certain criminal violations or have been the subject of sanctioning, debarment, exclusion, or other adverse action by an appropriate enforcement or regulatory agency of the federal or state government. Your Social Security Number will be stored by Harris Health System and provided to a third-party vendor on a monthly basis to screen you against various databases to determine whether you have been the subject of any of the actions described in the preceding sentence. See Harris Health System Policy 3.35, Screening for Ineligible Persons, for further information and authority.

Local Street Address	City	State	Zip
Permanent Street Address (If Different from Local Address)	**City**	**State**	**Zip**

Professional Degree	Institution Awarded By	Date Graduated

Home Telephone #	Cell Phone #	Pager #	E-mail Address

Emergency Contact Information			
Name		Relationship	
Phone Number		Alternate Phone Number	

I hereby authorize the Harris Health System Medical Staff Services to utilize the information herein and input into the Medical Staff Service data base as required. I understand that this information is for EPIC/Network access and IT Education pertinent to my medical educational rotation only. This information will be held confidential.

Signature: _____ Date: _____

HARRISHEALTH SYSTEM

HEALTH/IMMUNIZATION QUESTIONNAIRE

Completion of this form will meet most information requirements of the Harris Health System and its Medical Staff. It must be completed in its entirety and honestly. Should need for additional explanation be needed, appropriate space is provided at the end of each section. When doing so, reference the particular question by number.

HEALTH STATUS

To answer this question appropriately, you must report any condition which affects your motor skills or cognitive ability or judgment; or, which may adversely affect your ability to care for patients or to interact appropriately with caregivers.

1) **Do you currently have or have you ever had a physical or mental health condition which has affected or would affect your ability to exercise clinical privileges; or, would require an accommodation in order for you to exercise the privilege(s) you have requested safely and competently? ☐ Yes ☐ No**
2) **Have you ever or are currently engaged in the unlawful use of drugs? ☐ Yes ☐ No**
3) **Have you ever had or do you now have an alcohol consumption problem? ☐ Yes ☐ No**

If you have answered yes to any of the questions above, please explain in the space below. If you answered "yes" to either Question 2 or 3, you must identify and describe any rehabilitation program in which you are currently enrolled or have been enrolled, which assures abstinence prospectively and your adherence to prevailing standards of professional performance; and/or, assures, if appropriate, that alcohol consumption will not interfere with your practice of medicine, patient care responsibilities or adherence to prevailing standards of professional performance.

_____
_____
_____

TB STATUS and IMMUNIZATIONS

1. **TB Status: Harris Health System requires all faculty and healthcare providers to remain current with yearly TB testing.**

☐ I attest that I have had a TB skin test within the past twelve (12) month and the results have found to be negative.
or
☐ I attest that I have had a TB skin test with positive results, followed by a negative CXR and I have no symptoms of active disease.
or
☐ I attest that I currently have TB symptoms that are under treatment. I have attached appropriate documentation.
(If you checked here, you must give a full explanation in the space provided at the end of this section.)

2. **Have you ever had Chickenpox or the Varicella (Chickenpox) vaccine? ☐ Yes ☐ No**

3. **Have you had Measles, Mumps or Rubella or the MMR vaccine? ☐ Yes ☐ No**

4. **Have you had Hepatitis B or the HepB vaccine? ☐ Yes ☐ No**

5. **Have you had a Tetanus booster within 10 years or the Tetanus-Diphtheria-Pertussis (Tdap) vaccine?**
☐ Yes ☐ No

6. **Have you had an influenza vaccine within the past 12 months? ☐ Yes ☐ No If yes, provide date: _____(mm/yy)**
***Proof of Flu-vaccine or approved exemption is required for the current Flu Season (November 1-April 30).**

Please clarify any additional information pertinent to your current health and/or immunization status in the space below:

_____
_____
_____

_____ _____
Signature **Printed Name**

_____
Date

HARRISHEALTH SYSTEM

Certificate Compliance Form

As part of your application with the Harris Health System, you must initial each item acknowledging that you have read and understand the information presented to you and return with your application. Your name, signature, and date are required at the bottom of this form.

_____ 1. I have read and understand the enclosed *Harris Health System Code of Conduct*. I understand that compliance with this Code is a condition to my ability to practice my profession at Harris Health System. I further understand that violation of the Code may result in disciplinary action as provided in the Bylaws of the Medical Staff.

_____ 2. I have read and understand the enclosed *Deficit Reduction Act* policy and will abide by it.

_____ 3. I have read and understand the enclosed *Reporting Fraud and Abuse, Wrongdoing and Non-Retaliation* policy and abide by it.

_____ 4. I am not (i) currently excluded, debarred, suspended, or otherwise ineligible to participate in the Federal health care programs or Federal procurement and non-procurement programs.

_____ 5. I have not been convicted of a criminal offense, expecting or awaiting the exclusion, debarment, suspension or otherwise being declared ineligible.

_____ 6. I am not on the General Services Administration's List of Parties Excluded from Federal Health Care Programs/EPLS (available on the Internet at (http://exclusions.oig.hhs.gov/), or the HHS/OIG List of Excluded Individuals/Entities (LEIE) (available through the Internet at http://oig.hhs.gov).

_____ 7. I will disclose immediately any debarment, exclusion, suspension, or any other event that makes me ineligible to participate in Federal health care programs or Federal procurement or non-procurement programs to Harris Health System Medical Staff Services Department and the Harris Health System Corporate Compliance Officer.

_____ 8. I understand that Harris Health System conducts annual screenings to monitor whether Medical Staff members are on exclusions and debarment lists, such as the OIG/LEIE and EPLS lists, will remove Medical Staff members that are found to be excluded or debarred from business operations related to Federal health care programs or services related to compensation through such programs.

_____ 9. I have received a copy of the materials that are used by Harris Health System for the annual compliance training.

_____ 10. I will disclose any conflict of interest that I may have related to any ownership interest and/or other relationships that are or may appear to be in conflict with my responsibilities to Harris Health System to Medical Staff Services and the Harris Health System Corporate Compliance Officer.

_____ 11. I understand that Medical Staff members should avoid conflict of interest related to their Medical Staff duties. I also understand that unavoidable conflicts should be disclosed and the Medical Staff member should not participate in any discussion, decision, or activity connected with the conflict.

The forgoing is true and correct to the best of my knowledge:

_____	_____	_____
Printed Name	**Provider ID#**	**Service**
_____	_____	
Signature	**Date**	

HARRISHEALTH SYSTEM

CODE OF CONDUCT

Certification and Acknowledgement

I acknowledge and certify that I have received and read the Harris Health Code of Conduct (Code), understand my obligations to comply with the Code, and have an affirmative duty to report compliance violations. I agree to comply with the Code found at:

http://policy/Policies/Code%20of%20Conduct.pdf

Employees: I understand that compliance with this Code is a condition of my continued employment. I further understand that violation of the Code may result in corrective disciplinary action, up to and including termination.

Initials: _____

Board of Managers: I understand that compliance with this Code is essential to my service on the Board of Managers of the Harris Health System.

Initials: _____

Medical Staff: I understand that compliance with this Code is a condition to my ability to practice my profession at Harris Health. I further understand that violation of the Code may result in disciplinary action as provided in the Bylaws of the Medical Staff.

Initials: _____

Contractors: I understand that compliance with this Code is a condition of my continued ability to furnish services to Harris Health. I further understand that violation of the Code may result in a termination by Harris Health of any relationship I have with Harris Health.

Initials: _____

Printed Name: _____ Department: _____

Signature: _____ Date: _____

SERVICEFIRST
Creating the Harris Health Experience

HARRISHEALTH SYSTEM

Harris Health Experience Commitment Statement

ServiceFIRST Interaction Standards

To ensure that I deliver an Exceptional Harris Health Experience with every interaction with patients, guests, and co-workers, I commit to exhibiting these specific behaviors:

FRIENDLINESS: Friendly, helpful greeting

"Welcome to Harris Health, my name is…, how may I help you?"
"Good morning, my name is Jane Smith, I look forward to taking care of you."
"Thank you for calling Harris Health, this is...how can I help you?"

INTEGRITY: "I" statements to show ownership

"I can help you with …"
"I will get someone who can help you with …"
"Is there anything I can do for you?"

RESPONSIBLITIY: Responsible for time expectations and next steps

Reset time expectations
Keep patients and coworkers informed
Describe and communicate next steps

SATISFACTION: Surroundings and personal appearance

Personal appearance: name badge on the upper part of your body, no lanyard
Adhere to dress code standards
Keep work areas/public areas clean and clutter free

TEAMWORK: Thank You

"Thank you for choosing Harris Health."
"Thank you for letting us take care of you."
"Thank you and have a healthy day."

I have read and understand my commitment and acknowledge that it is a standard for how those in our care shall be treated. I agree to follow the interaction standards listed above and deliver quality care and service to our patients. I understand that I am accountable for consistently exhibiting these behaviors.

Signature	Employee ID #	Date

HARRISHEALTH SYSTEM

Practitioner/Researcher Acceptable User Agreement

(Practitioners/Researchers requesting access to Harris Health System information systems MUST read and SIGN this form)

First Name	Middle Name	Last Name	Suffix

Title		Department	

Medical School Affiliation	☐ BCM ☐ UTH ☐ Other _____

E-mail Address assigned by School Affiliation	

I understand and agree that I shall use the information systems for Harris Health System for business purposes and:

1. I understand that any types of patient identifiable information as well as other types of business information are confidential. I will follow all applicable Harris Health policies to protect confidential and other types of information utilized in the course of Harris Health business that is created, maintained, or transmitted in any form (i.e. oral, written, or electronic) whether company developed or obtained from outside sources.
2. I understand that I am responsible for complying with all HIPAA Privacy and Security Policies.
3. I am aware that the data I create on Harris Health information systems remains the property of Harris Health.
4. I will not engage in any activity that is illegal under local, state, federal or international law while utilizing Harris Health-owned resources.
5. I will not disable Anti-Virus or Anti-Spyware and I will not download or install applications without written approval of the Information Security Department (InfoSec).
6. I will not install any hardware or network devices without written approval from InfoSec.
7. I will not remove electronic Protected Health Information (ePHI) from Harris Health facilities without written approval from my supervisor or such other approval as may be required by District policy.
8. I will not take photographs of patients or PHI/ePHI without written approval of the patient and my supervisor or PSA.
9. All approvals must be documented in writing (via e-mail) and on file with Harris Health IT Security Management Office.
10. I will use only my assigned user ID/Password to access Harris Health Information Resources whether at Harris Health facilities or accessing them remotely. I will protect my Password from use by others.
11. I will create a "hard to guess" password and notify IT if I think my Password has been compromised.
12. I will be accountable for any orders or data entered into the system under my ID and password.
13. I will use encryption to send ePHI via e-mail outside Harris Health.
14. I will not send unsolicited bulk emails (spam) or chain letters.
15. I will physically and logically secure all transportable devices and media that contain ePHI.
16. I will report Security Incidents to 800-500-0333, 713-566-6097 or 713-566-4344 or via e-mail to hipaa@hchd.tmc.edu.
17. I will call 713-566-4344 or e-mail hipaa@hchd.tmc.edu if I am unclear about how to handle a situation with regards to security.
18. I realize that I should have no expectation of privacy in my work-related conduct or the use of Harris Health owned or Harris Health provided equipment or supplies.
19. I also realize that Harris Health management reserves the right to examine electronic mail messages, files on personal computers, web browser cache files, web browser bookmarks, logs of web sites visited, computer system configurations, and other information stored on or passing through Harris Health computers.
20. I am aware Harris Health routinely logs the web sites visited, files downloaded, time spent on the Internet, emails and related information.
21. I may use the Harris Health information systems for limited personal use. I understand, however, that use of Harris Health information systems for personal use may subject me to disciplinary action if such use interferes with my job duties, involves conducting a private business on Harris Health time, or becomes excessive.
22. I realize that failure to comply with these statements and Harris Health HIPAA Privacy and Security policies and procedures may result in disciplinary action as described in the HIPAA Sanctions Policy (3.11.104)

SIGNATURE: _____ Date: _____

HARRISHEALTH SYSTEM

SCRUB STATION SYSTEM USER APPLICATION

(To be completed by Applicant, authorized by Department Manager, and returned to Linen Manager.)

Last Name: _____

First Name: _____

Middle Initial: _____

School Affiliation: ☐ BCM - BT ☐ UTH - LBJ

Department / Service: _____

Job Title / Designation: _____

HCHD Badge Number: _____

Number of Sets **2**

(Maximum of 2 sets of scrubs per applicant)

Security and Abuse of the System:

1. Each authorized user is responsible for the control of their account, including financial responsibility for theft, sharing, loaning, or other use of access information.

2. Any type of abuse of the system will result in termination of access to the system and the individual must pay for all attire not returned. The term abuse is classified but not limited to throwing foreign materials (other colored clothing, paper scrub apparel, towels, and trash) into the return system, attempting to falsify a transaction, and vandalism. The return system is equipped with electronic surveillance equipment designed to detect abuse.

By signing this document, you are agreeing to abide by procedure set forth by the Harris Health System for the use of the Scrub Station system.

Applicant:

Signature _____

Date _____