Yale NewHaven Health

YALE NEW HAVEN HEALTH
APPLICATION FOR SHORT TERM CLINICAL ROTATION

Please complete all information requested, including signature of the Section Chief/Chair of Department in which the Clinical Fellow is doing an elective rotation. Clinical Fellows must be licensed by the State of Connecticut or the employing institution must hold a PERMIT to practice medicine in Connecticut. In addition, Clinical Fellows who are graduates from foreign medical schools must submit a copy of their ECFMG certificate. Please return this form to YNHHS Medical Staff Administration, Hunter 416, New Haven, CT 06510 via fax (203-688-5343) or email iris.atkinson@westerlyhospital.org.

PART I- Demographic and education/training information:

NAME:		
HOME ADDRESS:		
DATE OF BIRTH:	**BIRTHPLACE:**	
SOCIAL SECURITY #:	**GENDER:**	
CT MEDICAL LICENSE #:	**EXPIRATION DATE:**	
MEDICAL SCHOOL/PROFESSIONAL SCHOOL:	**DEGREE:**	**GRADUATION DATE (MONTH/YEAR):**
ECFMG CERTIFICATE # (FOREIGN MEDICAL GRADUATES MUST ENCLOSE COPY):		
NPI#		
IMMUNIZATIONS: See attached for information and return immunization form with this application.		

PART II- Current Position:

HOSPITAL:		
ADDRESS:		
TELEPHONE #:	**FAX #:**	
FELLOWSHIP APPOINTMENT DATES: **From:**	**To:**	
FELLOWSHIP PROGRAM:	**ACGME APPROVED PROGRAM?** **YES NO**	
POSTGRADUATE YEARS (# of years in training since medical school):		
MALPRACTICE INSURANCE COVERAGE: Please forward a certificate of insurance with this application.		

PART III- Medical Staff Education Training:

Medical Staff Education Training is required for all new YNHHS applicants.

- **Click this link to see the Medical Staff Education Materials in PDF and review**
- **Then complete the post test here**
- **When prompted, fill in the blank areas of the post test then scroll down to submit. You must score an 80% in order to pass the test. If you do not get 8 or more questions correct you must retake the test until you do so.**
- **Include a screenshot of the webpage showing that you completed the test with this application.**

Indicate completion date:

PART IV- Rotation Schedule:

HOSPITAL (Check hospital at which rotation will occur):	DEPARTMENT:	SECTION:	START DATE:	END DATE:
BH GH LMH WH YNHH				
BH GH LMH WH YNHH				
BH GH LMH WH YNHH				

_____ _____

Signature, Clinical Fellow **Date**

_____ _____

Signature, Chief/Chair **Date**

_____ _____

Print Name, Chief/Chair **Date**

Indicate YNHHS Delivery Network:

BH GH LMH WH YNHH

PRACTICE HISTORY INFORMATION

If you answer "yes" to any of the following questions, you must supply full details on a separate sheet.

1. **STATE LICENSURE** Regarding your license to practice your profession in any jurisdiction:
   a. Has your application for a professional license ever been denied? Yes No
   b. Has your license ever been limited, suspended or revoked? Yes No
   c. Has the relevant licensing board ever investigated your professional practice or censured or sanctioned you for matters having to do with professional practice? Yes No
   d. Have you ever entered into a consent order, practice agreement, reinstatement order (or equivalent thereof) with any licensing board? Yes No
   e. Have you ever been fined or otherwise sanctioned by a state licensing board? Yes No
   f. Have you ever voluntarily surrendered your license? Yes No
2. Have you ever been, or are you currently, under investigation or involved in any proceeding or other disciplinary matter involving your practice before any state licensing board? Yes No

CONTROLLED SUBSTANCE PRESCRIBING

3. Have you ever been denied a state or federal certificate of authority to prescribe controlled substances or is your state or federal certificate of authority to prescribe controlled substances currently under investigation or has your authority to prescribe ever been under investigation? Yes No
4. Has your state or federal authority to prescribe controlled substances ever been voluntarily or involuntarily…
   a. limited by the agency? Yes No
   b. suspended? Yes No
   c. revoked? Yes No
   d. surrendered? Yes No
   e. denied renewal? Yes No

PROFESSIONAL MEMBERSHIPS

5. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action by any medical organization? Yes No
6. Have you ever been sanctioned or subject to disciplinary action by a specialty board or has your specialty or sub-specialty certification ever been suspended or revoked? Yes No

EDUCATION

7. In medical/professional school, internship, residency, post graduate training or fellowship, were you ever suspended, placed on probation, subject to disciplinary action, formally reprimanded or asked to resign? Yes No
8. Did you ever voluntarily resign or withdraw from any of the above programs? Yes No

COMPLIANCE

9. Has your eligibility to participate in the Medicare or Medicaid or any commercial insurance program ever been suspended or terminated or have you ever been threatened with exclusion or debarment from Medicare or Medicaid? Yes No
10. Have you ever been the subject of an investigation by any federal or state agency, including those agencies responsible for administering and overseeing the Medicare and Medicaid programs, or by any commercial insurance company, related to your professional practice, conduct or billing for health care services? Yes No
11. Have you ever been listed by the OIG (Office of Inspector General), GSA (General Services Administration), OFAC or any State (including the Connecticut Department of Social Services) as debarred, excluded or otherwise ineligible for Federal health program participation or otherwise sanctioned by the Federal government, including being listed on the EPLS (Excluded Parties List System)? Yes No
12. Have you ever been charged by any local, state or federal authority, official or agency, entered a plea of guilty or no contest or been convicted of any of the following:
    a. crimes or offenses related to the delivery of or billing for health care services under the Medicare or Yes No

Medicaid program?

b. crimes or offenses related to the abuse or neglect of patients in connection with the delivery of health care? Yes No

c. crimes or offenses involving fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state or local government? Yes No

d. obstruction of justice? Yes No

e. crimes or offenses related to the manufacture, distribution, prescription or dispensing of any controlled substance? Yes No

f. any other felony or misdemeanor crimes or offenses (excluding only motor vehicle speeding violations and parking tickets)? Yes No

HEALTH CARE FACILITY MEMBERSHIP & PRIVILEGES

13. Have you ever been denied privileges or medical staff membership at any hospital or other health care facility? Yes No
14. Have you ever been the subject of a professional review action or any disciplinary action at any hospital or health care facility and/or have you ever been a party to a hearing under any set of medical staff bylaws? *Defined as- adverse clinical privilege actions related to professional competence or conduct Yes No
15. Have your hospital or other health care facility privileges or medical staff membership ever been voluntarily or involuntarily cancelled, challenged, reduced, surrendered, limited, suspended, not renewed, revoked or withdrawn? Yes No
16. Have there been any adverse professional actions or other disciplinary actions ever been made against you related to disruptive behavior or unprofessional conduct? Yes No

HEALTH / BEHAVIORAL

17. Are you dependent upon any controlled substance or alcohol? Yes No
18. Are you presently using illegal controlled substances (i.e. controlled substances for which you do not have a prescription from your healthcare provider or that you are using contrary to the prescribed dosage) or are you presently dependent on alcohol? Yes No
19. With or without reasonable accommodation, do you have any physical, mental or emotional condition or dependency that would compromise your ability to competently and safely exercise the clinical privileges requested? Yes No
20. Has formal disciplinary action or professional review action ever been imposed on you? Yes No

LIABILITY HISTORY

Please note that minimum insurance limits for the Medical Staff of $1 million per occurrence and $3 million in the aggregate is required (proof of insurance coverage is required).

21. Have you ever been reported to the National Practitioner Data Bank by any individual or organization for any reason? Yes No
22. Has any malpractice or professional liability claim been brought against you?
    If yes, please complete the attached "Claim/Suit Report" for each case and describe the case indicating the following:
    a. date and details of the incident(s)
    b. your role in the incident(s)
    c. current status of the claim
    d. if settled, amount paid
    e. if pending, amount being sought
    f. professional liability insurer involved Yes No
23. Have you ever been denied professional liability coverage or has your professional liability coverage ever been revoked or not renewed by action of the insurer? Yes No

Name _____
Please PRINT

CONFLICTS OF INTEREST

All Medical Staff members of any YNHHS affiliate shall comply with the YNHHS Conflicts of Interest Policy (Policy Number: CC:R-1, located on the YNHHS Intranet or by contacting the YNHHS Office of Privacy and Corporate Compliance), including responsibility for disclosing actual or potential conflicts of interest as described and in accordance with the Policy.

By signing below I am attesting to the truth, accuracy, and completeness of the information provided in this application, and specifically acknowledging, without limitation, the Misrepresentation and Omissions provisions of the attached Authorization and Release.

Signature of Applicant:_____

Date:_____

YALE NEW HAVEN HEALTH
IMMUNIZATION TESTING RECORD

DOCUMENTATION OF IMMUNIZATIONS/TITERS		
	DATES of vaccine or titer	**TITER RESULT**
MEASLES VACCINE (dates for both doses) **or**		N/A
MEASLES TITER (if no vaccine)		
RUBELLA VACCINE (dates for both doses) **or**		N/A
RUBELLA TITER (if no vaccine)		
MUMPS VACCINE (dates for both doses) **or**		N/A
MUMPS TITER (if no vaccine)		
VARICELLA VACCINE received (2 doses of Varivax) **or**		N/A
History of physician-diagnosed illness (chicken pox, herpes-zoster)		N/A
VARICELLA TITER (if neither of the above)		
TETANUS-DIPTHERIA-PERTUSSUS VACCINE received (must be since 2005)		N/A
TB SKIN TEST (negative within past 12 months) **or**		N/A
IGRA (negative within past 12 months)		N/A
INFLUENZA VACCINE (annual)		N/A
COVID-19 VACCINE (dates for doses and brand of vaccine) ALSO UPLOAD IMAGE OF VACCINATION CARD OR DOCUMENTATION FROM ELECTRONIC MEDICAL RECORD		N/A

PPD or IGRA Positive

If **PPD/IGRA** positive, did you have a chest x-ray: **YES**_____(please include results) **NO** _____

If **PPD/IGRA** positive, did you receive prophylactic anti-tuberculosis therapy? **YES**_____ **NO** __ __

HEPATITIS B

Have you received the **Hepatitis B** Vaccine series? **YES**_____ **NO**____

If no, you must complete the Hepatitis B declination and waiver form.

If yes, what was the result of your **Hepatitis B** surface antibody test following the vaccine series?

POSITIVE_____ **NEGATIVE**__ __

YALE NEW HAVEN HEALTH
HEPATITIS B VACCINE DECLINATION

(Please sign if you are declining HepB vaccination):

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

_____

(Signature)

_____

Please print Full Name

_____

(Date)

YALE NEW HAVEN HEALTH
MEDICAL STAFF REQUIREMENTS
IMMUNIZATIONS AND TB SURVEILLANCE

Based upon current standards of OSHA/AHA/CDC/Joint Commission and YNHHS policy, applicants to the Medical Staff and Clinical Fellows are required to submit their immunization/test records to Medical Staff Administration along with the application for appointment. For your convenience, a standardized reporting form is enclosed. The following documentation is required:

- **MEASLES** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **RUBELLA** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **MUMPS** (for those whose DATE OF BIRTH is 1/1/57 or later), statement of history of illness is not acceptable: A statement of date of positive antibody titer
  Or
  Dates of Immunization with MMR vaccine (2 doses subsequent to first birthday)

- **HEPATITIS B**
  A statement of date of positive hepatitis b surface antibody titer
  Or
  Date of completion of Immunization series
  Or
  Signed attached declination and waiver

- **VARICELLA-ZOSTER VIRUS**
  A statement of history of physician-diagnosed illness (chicken pox, shingles, or herpes-zoster)
  Or
  Dates of Immunization with Varivax (2 doses)
  Or
  Result of antibody titer.

- **TETANUS-DIPHTHERIA-PERTUSSIS**
  Date of immunization with Tdap since 2005

- **TB SKIN TEST**
  A negative 2-step PPD within the most recent 12 months
  Or
  For those with two years of serial PPD testing, a single baseline negative PPD within most recent 12 months
  Or
  A negative Interferon Gamma Release Assay (IGRA) result for TB within past 12 months

Or
For those with a positive PPD or positive IGRA, date of evaluation for Latent TB Infection (LTBI) and a chest radiograph report subsequent to positive PPD or positive IGRA.

Members of the Medical Staff with negative PPD or negative IGRA result will be required to document annual PPD or IGRA testing during the bi-annual re-credentialing process.

- **INFLUENZA**
  Vaccination required annually: evidenced by documentation from OHS, attestation by practitioner of vaccine receipt, or statement of declination for medical or religious reason.

- **COVID-19** statement of history of illness is not acceptable
  The brand and date(s) of vaccine and booster must be included on the immunization form
  And
  An image of vaccination card or documentation from electronic medical record must be provided, which includes the initial two doses of Moderna or Pfizer, or one dose of J&J, **and** a booster dose

Special Considerations for Lawrence and Memorial and Westerly Hospitals:

Medical Staff of Lawrence and Memorial and Westerly Hospitals ***not*** employed by NEMG are strongly recommended to receive influenza vaccine, but may decline the vaccine.

ADDITIONAL REQUIREMENTS

Medical Staff who care for patients in negative pressure isolation rooms are expected to complete fit testing for the N95 respirator on an annual basis. Medical Staff who interpret tests requiring color discernment (e.g. dipstick of urine) should have normal color vision. YNHHS Occupational Medicine and Wellness Services (OMWS) Clinics are available to carry out N95 fit testing and Ishihara color vision screening for Medical Staff members at no charge. OMWS Clinics also are available at no charge to Medical Staff members who require additional vaccine doses or serological testing for vaccine response. Medical Staff members may contact OMWS at the following numbers:

YNHH YSC: 203-688-2462 (1st floor, YNHH YSC East Pavilion)
YNHH SRC: 789-3721 (175 Sherman Avenue, 5th floor)
Bridgeport Hospital 203-384-3613 (226 Mill Hill Ave # 2)
Greenwich Hospital203-863-3400 (Watson Pavilion, 2nd floor)
L&M Hospital 860-442-0711, ext. 2289 (L&M Hospital)
Westerly Hospital 401-348-3783 (Westerly Hospital)