Baylor College of Medicine
Office of Graduate Medical Education

Visiting House Staff Physician Elective Information

Please complete the information required. Please type or print all responses. Applications which are not legible will be returned to the applicant.

A program letter of agreement between Baylor College of Medicine and the elective trainee's institution is required before the trainee may begin his/her elective. You may obtain a template from your Baylor College of Medicine Departmental Education Office. This process will take approximately 3 months to complete.

When complete, please forward all information to the education office associated with the program in which you will be working. The Office of Graduate Medical Education (OGME) will only accept applications from Baylor College of Medicine Departmental Education Offices, to ensure that all approvals program/department-specific have been obtained prior to OGME processing.

Please provide the following:

- ☐ Completed Elective Application
- ☐ BCM Liability Release Form
- ☐ Proof of Professional Liability Coverage at the 1m/3m levels
- ☐ Background Check & Drug Screen (Completed through CertifiedBackground.com)*
- ☐ Copy of Texas Medical License or Permit. Outside rotators should contact the Texas Medical Board for instructions on obtaining a Rotator Physician in Training Permit. They may be contacted at pits@tmb.state.tx.us
    - ☐ Copy of Current DEA and DPS Certificates (if fully licensed in Texas)
- ☐ Copy of Current ACLS, PALS, or ATLS Certification (must be AHA certified)
- ☐ Proof of Current HIPAA Training
- ☐ Complete Immunizations Record
- ☐ Processing Fee (waived for US Military trainees & Affiliated hospitals in the Med Center):
    - ☐ $500 if GME is notified at least 90 days prior to start
    - ☐ $750 if GME is notified less than 90 days prior to start
    - ☐ $1250 for any elective scheduled between June 1 – July 31

    **Fee is non-refundable.*

*Affiliates within the Texas Medical Center Consortium (UT Houston, The Methodist Hospital, and MD Anderson Cancer Center) do not need to provide proof of these items.

**Effective immediately, BCM no longer accepts VISA holders for electives.

Visiting House Staff Flow Sheet

From: **To:**

Position Number

Name:

Baylor ID Number

Department:

Termination Date

Hospital:

Date Termed in SAP

Program Coordinator:

DOCUMENTS REQUIRED	Verified by Department Initial & Date
Elective Application	
BCM Liability Release Form	
Proof of Current Institution Professional Liability Coverage (1m/3m)	
Background Check / Drug Test *(for non-affiliate rotators)*	
Copy of FULL TEXAS LICENSE / Permit (Proof of DEA and DPS Registration required if on a full TX license)	
Copy of Current ACLS, PALS or ATLS certification *(must be American Heart Association certified)*	
Proof of Current HIPAA Training	
Completed Immunization Record	
Processing Fee: *fee is non-refundable*	

Notes:

Check-in Date: **By:**

THERE WILL BE NO EXCEPTIONS

INCOMPLETE PACKETS WILL NOT BE PROCESSED
AND WILL BE RETURNED TO RESPECTIVE COORDINATORS

BAYLOR COLLEGE OF MEDICINE

RESIDENT/FELLOW ELECTIVE APPLICATION (Rotators from Outside BCM)

I. IDENTIFYING INFORMATION	TYPE OF LEARNER:
Anticipated Dates of Rotation: Start Date: End Date:	Resident or Fellow:
Specialty/Subspecialty where you wish to rotate:	
Have you ever been to Baylor College of Medicine before? (if you have ever had a BCM ID #, check yes) ☐ Yes ☐ No If yes, when? What Service/Program?	

Last Name:	First Name:	Middle Name:	MD/DO

Social Security Number:	Date of Birth:	Place of Birth:

Are you a US Citizen?	☐ Yes ☐ No (if No, answer the following questions)	Country of Citizenship:
Are you a Permanent Resident?	☐ Yes → Attach a copy of your "Green Card" * If no – BCM does not accept visa holders for elective rotations	

II. ADDRESS	
Home Address:	
City, State, Country, Zip/Postal Code:	
Home Phone:	Cell Phone:
Permanent Email Address:	

III. A. EMERGENCY CONTACT INFORMATION	
Name:	Relationship:
Complete Mailing Address:	
Home Phone:	Other Phone:

IV. LICENSURE		
	Certificate Number:	Expiration Date:
Full Texas License/Texas Physician In Training Permit:(attach a copy)		
Other Licensure: (i.e. pharmacy, etc) Type:		
DEA: (attach copy only if you have a full license)		
DPS: (attach copy only if you have a full license)		
NPI: National Provider ID Number		

V. ALTERNATE NAME DOCUMENTATION

Each applicant who has recorded an alternate name on this application that is different than shown on their attached supporting documentation must submit copies that support the name change. This list contains but is not limited to: marriage certificate, divorce decree, court ordered name change or other official documentation.

VI. EDUCATION		
A. UNDERGRAUDATE EDUCATION (last to first in chronological order)	**Dates Attended:**	
1. Name of Institution:	From: (mm/yy)	To: (mm/yy)
City, State	Date Degree Awarded:	Degree:
2. Name of Institution:	From: (mm/yy)	To: (mm/yy)
City, State	Date Degree Awarded:	Degree:

B. MEDICAL SCHOOL or HEALTH PROFESSIONS SCHOOL (last to first in chronological order)	
Name of Institution:	Dates Attended: From: (mm/yy) To: (mm/yy)
City, State	Date Degree Awarded: Degree:

C. POST GRAUDATE TRAINING		
List in chronological order <u>every postgraduate training program</u> you have been associated with. Attach additional sheets if necessary. Reference this section number and title.		
1. Current Institution:		Dates Attended: From: (mm/yy) To: (mm/yy)
Program Name:		PGY Level:
Mailing Address:		Program Director:
City:	State & Zip:	Phone:
Country:		Fax:
Did you successfully complete the program? ☐ Yes ☐ No (If, NO, please explain on a separate sheet and reference this section and Program)		
2. Institution:		Dates Attended: From: (mm/yy) To: (mm/yy)
Program Name:		PGY Level:
Mailing Address:		Program Director:
City:	State & Zip:	Phone:
Country:		Fax:
Did you successfully complete the program? ☐ Yes ☐ No (If, NO, please explain on a separate sheet and reference this section and Program)		

VII. To be completed by the director of the training program in which the house office is currently enrolled (not BCM)

ACGME or TMB Program # :

The house office:	**YES**	**NO**
Is in good standing in our program	_____	_____
Is approved to take this elective rotation	_____	_____
Is covered by our program for Malpractice insurance with minimum acceptable coverage: **$1,000,000 per occurrence/ $3,000,000 in the aggregate***	_____	_____

Name and Title: _____

Signature: _____

*** If yes, attach a copy of the certificate of insurance**

VIII. To be completed by the Baylor department providing the elective

Approved: _____ Disapproved: _____
(Chairman or Designee Signature) (Chairman or Designee Signature)

Date: _____

The house office should report to:

Person: _____ Date: _____

Location: _____ Room Number: _____

House officer will rotate at this hospital(s): _____

IX. GENERAL HEALTH

Do you have any medical conditions that might impair your participation in the program? ☐ Yes ☐ No
If so, please describe.

I certify that my answers are true and complete to the best of my knowledge. I understand that false, misleading or incomplete information may result in my release from the rotation. I also understand that the host program has the right to terminate my rotation at anytime for cause.

Signature:_____ **Date:**_____

Full Release of

Baylor College of Medicine

From All Liability

I understand that in connection with my voluntary participation in the clinical training experience at Baylor College of Medicine, I will be offered the opportunity to work in hospital or clinic settings, which may be hazardous. In these settings, I may come into contact with:

1. communicable or infectious diseases, including by way of example, tuberculosis, HIV, hepatitis;
2. radioactive devices and substances;
3. biologically hazardous materials;
4. dangerous equipment; and
5. other substances or things which are unfamiliar to me and which could cause serious injury to me, including death.

Additionally, I may be exposed to other potentially harmful situations and equipment commonly encountered in a medical environment where patients are treated, such as operating suites, emergency departments, labor and delivery suites, and intensive care units. As a result of the hazardous environment at the school and its affiliated hospital and clinics, I understand that there is the potential for me to be seriously injured or even killed or to sustain serious damages.

In consideration of the experience and training which I will receive at Baylor College of Medicine, which I expressly state will be of great value to me and my career and which will greatly enhance my educational experience as a physician in training, I _____, do hereby release and hold harmless Baylor College of Medicine, its trustees, officers, employees, faculty, staff, and all other persons, firms, subsidiaries, corporations or other entities, including Baylor-affiliated hospitals and other healthcare entities which might be liable, from any and all claims, demands, lawsuits, causes of action, known or unknown, of whatever nature whether for personal injury (including a serious disease) or death, or otherwise which may accrue to me, my heirs, executors, legal representatives, successors or assigns for or on account of my voluntary participation in the clinical training experience at Baylor College of Medicine.

_____

Signature of Participant

_____

Title Date

Check One:

Post-Doctoral Fellow_____ Resident_____ Student_____

If student (Externship) is under the legal age of 21, a parent or guardian must sign and his/her signature must be notarized.

_____
Parent or Guardian

_____
Date

THE STATE OF TEXAS §
§
THE COUNTY OF HARRIS §

BEFORE ME, the undersigned authority in and for said county and state, on this day personally appeared_____, known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that (he/she) executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF THIS OFFICE this _____ day of _____, 20__.

_____
Notary Public in and for the State of Texas,
County of Harris

(SEAL)

CertifiedBackground.com

STUDENT INSTRUCTIONS FOR BAYLOR COLLEGE OF MEDICINE
GENERAL MEDICAL EDUCATION

About CertifiedBackground.com

CertifiedBackground.com is a service that allows students to order their own background checks online, as well as place and track drug tests. Information collected through **CertifiedBackground.com** is secure, tamper-proof and kept confidential. The services performed are based on guidelines provided by your school, so you know you will receive all the information you need from one source. Your results will be posted on the **CertifiedBackground.com** website where the student, as well as the school, can view them.

Before Placing Your Order

- **Required Personal Information**
  - In addition to entering your full name and date of birth, you will be asked for your social security number, current address, phone number and email address.
- **Drug Test (LabCorp)**
  - After you place your order, you will receive an email directly from the lab with the subject line: "**LabCorp**" within 24-48 hours. This email will explain where you need to go to complete your drug test and contain the electronic form required for the drug test.
- **Payment Information**
  - At the end of the online order process, you will be prompted to enter your Visa or Mastercard information. Money orders are also accepted but will result in a $10 fee and an additional turnaround time.

Place Your Order

Go to: www.CertifiedBackground.com, click on "**Students**" & enter package code:

AY25 – Background Check + Drug Test

AY25BC – Background Check Only

AY25DT – Drug Test Only

AY25R – Recheck Only

View Your Results

After placing your order on **CertifiedBackground.com**, you will receive a confirmation email that will contain the password needed to access your results and view any missing information required to process your order.

Go to: www.CertifiedBackground.com, enter the password provided, then click "**View**". On the next screen, enter the last 4 digits of your social security number to access your information.

To see your order status, return to **CertifiedBackground.com** with your password . Your order will show as "**In Process**" until it has been completed in its entirety. Your school's administrator can also securely view your results online with their unique username and password.

If you have any additional questions, please contact Certified Background Student Support at (888) 666-7788 Ext. 1 or email: customerservice@certifiedbackground.com.

2012

Start Date_____
End Date_____

Occupational Health Program

VISITING RESIDENT/FELLOW IMMUNIZATION RECORD

Name _____ Date of Birth_____ Phone_____

Residency/Fellowship Program_____ Email _____

Complete form and ATTACH SUPPORTING DOCUMENTATION

	DATE
A. **Tetanus-Diphtheria (Tdap- Tetanus-Diphtheria-Pertussis is preferred)** 1. _____Completed primary series of tetanus-diphtheria immunizations. 2. _____Received tetanus-diphtheria-pertussis (Tdap) booster within the last 10 years. (attach record)	_____ _____
B. **M.M.R. (Measles, Mumps, Rubella)** (please document each dose) 1. _____Dose 1: Immunized at 12 months or after. (attach record) 2. _____Dose 2: Immunized after 1980. (attach record)	_____ _____
C. **Measles (Rubeola)** - If given instead of M.M.R. check appropriate item I. _____Born before 1957, considered immune. 2. _____Serologic proof of immunity. (attach record) 3. _____Immunized with live virus, **twice**, at least once after 1980. (attach records)	_____ _____ _____
D. **Rubella** - If given instead of M.M.R. check appropriate item 1. _____Serologic proof of immunity. (attach record) 2. _____One dose of vaccine on or after 1st birthday. (attach record)	_____ _____
E. **Mumps**- If given instead of M.M.R. check appropriate item 1. _____Born before 1957, considered immune. 2. _____Serologic proof of immunity. (attach record) 3. _____One dose of vaccine on or after 1st birthday. (attach record)	_____ _____ _____
F. **Varicella (Chickenpox)** 1. _____Serologic proof of immunity. (attach record) 2. _____Immunization (2 doses) (attach record)	_____ _____
G. **Tuberculosis** 1. _____Last PPD (Mantoux) test (for record purposes). You will be tested at Baylor. Give date and test result. _____Millimeter 2. _____Had BCG vaccine. If yes, PPD still has to be done. 3. _____If ever positive PPD, (greater than 10 mm induration) or IGRA blood test positive, chest x-ray done within last year is required. (attach x-ray report)	_____ _____ _____
H. **Hepatitis B** -give dates for all administered shots 1. _____Serologic proof of immunity. (attach record) 2. _____Immunization (at least 3 doses and attach records)	_____ _____ _____ _____

PLEASE RETURN THIS FORM (via facsimile or mail) TO::

Occupational Health Program
Baylor College of Medicine
1 Baylor Plaza- (Mail Stop BCM608)
Houston, TX 77030

713-798-7880
713-798-3364 (confidential fax)

2/29/2012

BAYLOR OCCUPATIONAL HEALTH
Phone (713)798-7880 Fax(713)798-3364

IMMUNIZATION REQUIREMENTS FOR VISITING RESIDENTS AND FELLOWS

Requirements based on Texas Department of State Health Services, OSHA policy and Centers for Disease Control recommendations.

Tetanus/Diphtheria:	Basic Series plus 1 dose within last 10 years. Tdap (Tetanus-diphtheria-pertussis) is preferred.
Measles (Rubeola):	Applies only to those born after December 31, 1956**.** Acceptable proof of prior immunization with 2 doses of vaccine on or after first birthday at least 30 days apart and one dose given since 1980; or serologic confirmation of immunity.
Rubella:	Acceptable proof of prior immunization with 1 dose of vaccine on or after first birthday; or serologic confirmation of immunity.
Mumps:	Applies only to those born after December 31, 1956. Acceptable proof of prior immunization with 1 dose of vaccine on or after first birthday; or serologic confirmation of immunity.
Tuberculosis:	A PPD within a year prior to the end of your rotation. This must be placed and read by a health care practitioner in the regular course and scope of their practice. Only Mantoux results (in mm) for a skin test are accepted; or Proof of a positive test is provided. A history of a positive test is not accepted. If positive, chest x-ray is required. Interferon-gamma blood tests are also accepted.
Hepatitis B:	Series of three: first dose, second dose 1 month after the first dose and third dose 5 months after second dose; or serologic confirmation of immunity
Varicella:	Serologic proof of antibody; or immunization (2) at appropriate interval
Meningitis	Completion of questionnaire Immunization is not required
Declination:	Medical contraindication; or member of acknowledged religious group that does not allow immunization (with written letter from leader of group).

BCM
Baylor College of Medicine

Baylor Occupational Health Program
713-798-7880 Fax 713-798-3364

Section I: Employee Information (please print)

Name: _____ BCM ID: _____ SSN: _____
Last First MI

Date of Birth: _____ Age: _____ Phone Number: _____

Section II: Respirator/Work Information (Check all that apply)

DURATION OF RESPIRATOR USE:
___Only during patient care activities
___Only during emergency situations
___Regularly, but less than 5 hrs./week
___1-2 hours per day every day
___Over 2 hours per day every day

LEVEL OF EXERTION DURING RESPIRATOR USE:
___Light (mainly sedentary work, no lifting)
___Moderate (lifting up to 20 pounds occasionally)
___Heavy (carrying over 20 pounds or climbing frequently)

Section III: Medical History / Symptom Review

Do you have or have you ever had any of the following medical conditions?

___Heart Attack
___Angina
___Heart failure
___Heart arrhythmias
___Other heart disease:
_____
___Stroke
___Tuberculosis
___Asthma
___Emphysema
___Pneumothorax (lung collapse)
___Any surgery or serious injury to the chest
___Chronic bronchitis (with current symptoms)
___Pneumonia (if yes, when _____)
___Other lung disease _____
_____
___Anemia
___Skin allergies or rashes (if yes, substance _____)

Do you have or have you had any of the following problems? Please check any symptoms which you think are <u>out of the ordinary.</u>

___Shortness of breath (more than other people your age)
___Persistent cough (outside of colds)
___Wheezing (outside of colds)
___Persistent chest pains
___Palpitations or skipped heart beats
___Loss of consciousness

Are you taking any medications? ____Yes ____No

If yes, please list _____
Have you smoked within the last 30 days? ____Yes ____No
Have you ever worn a respirator before ____Yes ____No
If yes and you had problems with respirator use, please explain:
_____

I understand that the above information is used to determine my ability to wear a respirator for protection from tuberculosis. The information I have furnished is true to the best of my knowledge. If I experience a significant change in my health status, I will notify Baylor Occupational Health..

Signature _____ Date _____

OHP use: Reviewer _____ ___Y ___N Date _____

BCM
Baylor College of Medicine

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOUR MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice

We are required by law to maintain the privacy of your protected health information (PHI). This notice applies to all records of the health care and services you received at BCM. This notice will tell you about the ways in which we may use and disclose your PHI. This notice also describes your rights and certain obligations we have regarding the use and disclosure of your PHI.

Who Will Follow this Notice

This notice describes BCM's privacy practices, as well as the privacy practices of:

a. any health care professional authorized to enter information into your BCM medical record;
b. all departments, clinics, sections and units of BCM;
c. any member of a volunteer group that interacts with you while you are at BCM; and
d. all employees, staff, students and other BCM personnel.

BCM's Commitment

We are required by law to:

a. make sure that your PHI is kept private;
b. give you this notice of our legal duties and privacy practices with respect to your PHI;
c. follow the terms of this notice as long as it is currently in effect. If we revise this notice, we will follow the terms of the revised notice as long as it is currently in effect;
d. train our personnel concerning privacy and confidentiality; and
e. mitigate (lessen the harm of) any breach of privacy/ confidentiality.

Understanding Your Health Record

Each time you visit a BCM clinic, hospital, physician or affiliated health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for care or treatment. This information, often referred to as your health or medical record, serves as a:

a. basis for planning your care, treatment and any follow up care you may need;
b. means of communication among the many health professionals who contribute to your care;
c. legal document describing the care you received;
d. means by which you or a third-party payer (for example, insurance carriers, Medicare, Medicaid) can verify that services billed were actually provided;
e. tool in educating heath professionals;
f. source of information for medical research;
g. source of information for public health officials charged with improving the health of the nation;
h. source of information for facility planning and marketing; and
i. tool which can be used to assess and continually improve the care rendered and the results achieved.

Understanding what is in your record and how your health information is used helps you to:

a. ensure its accuracy;
b. better understand who, what, when, where and why others may access your health information; and
c. make more informed decisions when authorizing disclosure to others.

How We May Use and Disclose Information about You

The following categories (listed in bold-face print, below) describe different ways that we use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and give you some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information fall within the categories below.

For Treatment. We are permitted to use and disclose your PHI to doctors, nurses, technicians, medical students or other personnel who are involved in taking care of you at BCM or provide you with medical treatment or services. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that the dietitian can arrange for appropriate meals. Different departments of BCM also may share your PHI in order to coordinate the different services that you need, such as lab work, x-rays, and prescriptions. We also may disclose your PHI to health care providers outside BCM who may be involved in your medical care, such as physicians who will provide follow-up care, physical therapy organizations, medical equipment suppliers, and skilled nursing facilities.

For Payment. We are permitted to use and disclose your PHI so that the treatment and services you receive at BCM may be billed to (and payment may be collected from) your insurance company or a third party. For example, we may need to give your health plan information about the surgery you received at BCM so your health plan will pay us or reimburse you for the surgery. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We are permitted to use and disclose your PHI for our business operations. These uses and disclosures are necessary to run BCM and to make sure that all of our patients receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the performance of our staff in caring for you. We also may disclose information to faculty physicians, nurses, technicians, house staff (including residents and interns), medical students, and other BCM personnel to conduct training programs. We also may combine certain PHI about several BCM patients as part of a study to determine what

additional services BCM should offer, what services are not needed, and whether certain new treatments are effective. We also may remove all information that identifies you from a set of PHI so that others may use that information to study health care and health care delivery without learning who the specific patients are.

To Business Associates for Treatment, Payment and Health Care Operations. We are permitted to disclose your PHI to our business associates in order to carry out treatment, payment or health care operations. For example, we may disclose your PHI to a company we hire to bill insurance companies on our behalf to help us obtain payment for the health care services we provide.

Hospital Directory. Unless you express an objection, we are allowed to include certain limited information about you in the Patient Directory while you are a patient in a BCM hospital. This information may include your name, your location at BCM (for example, Intensive Care Unit, Labor & Delivery), your general condition (for example, fair, stable, good) and your religious affiliation. The directory information, except for your religious affiliation, also may be released to people who ask for you by name. Your religious affiliation may be given to a member of the clergy, such as a priest or rabbi, even if the clergy member does not ask for you by name. The purpose of the Patient Directory is to allow your family, friends and clergy to visit you at BCM and know how you are doing. If you cannot provide your objection to these uses and disclosures because of incapacity or an emergency treatment circumstance, we may use or disclose some or all of this information if that disclosure is consistent with what you have told us previously and if the disclosure is in your best interest as determined in the exercise of our professional judgment.

Individuals Involved in Your Care or Payment for Your Care. We may release your PHI to a family member, other relative or close personal friend who is involved in your medical care if the PHI released is directly relevant to the person's involvement with your care. We also may release information to someone who helps pay for your care. We also may tell your family or friends that you are at BCM and what your general condition is. In addition, we may disclose your PHI to a group assisting in a disaster relief effort so that your family can be notified about your location and general condition.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at BCM.

Treatment Alternatives. We may use and disclose medical information to give you information about treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits, educational programs, or services that may be of interest to you.

Fund raising Activities. We may use certain allowable PHI with your permission to contact you in an effort to raise money for BCM and its operations. This limited PHI includes demographic information about you (for example, your name, address, phone number), and the dates you received treatment or services at BCM. If you do not want us to contact you for our fund raising efforts, please contact the **Office of Development** at 713-798-8675.

Special Situations

As Required By Law. We will disclose your PHI when required to do so by federal, state, or local law.

Public Health Activities. We may disclose your PHI for public health activities. For example, public health activities generally include:

a. preventing or controlling disease, injury or disability;
b. reporting births and deaths;
c. reporting child abuse or neglect;
d. reporting reactions to medications or problems with products;
e. notifying patients of recalls of products they may be using;
f. notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; or
g. notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

a. in response to a court order, subpoena, warrant, summons or similar process;
b. to identify or locate a suspect, fugitive, material witness or missing person, but only if limited information (e.g., name and address, date and place of birth, Social Security number, blood type and RH factor, type of injury, date and time of treatment, and date and time of death, if applicable) is disclosed;
c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
d. about a death we believe may be the result of criminal conduct;
e. about criminal conduct we believe occurred on BCM's premises; and
f. in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release PHI about patients of BCM to a coroner or medical examiner to identify a deceased person or to determine the cause of death. We may also release PHI about patients of BCM to funeral directors as necessary to help them carry out their duties.

Organ and Tissue Donation. We may release PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Research. Under certain circumstances, we may use and disclose your PHI for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. Most research projects, however, are subject to a special approval process. This process requires an evaluation of the proposed research project and its use of PHI, and balances these research needs with our patients' need for privacy. Before we use or disclose PHI for research, the project will have been approved through this special approval process. However, this special approval process is not required when we allow researchers who are preparing a research project to look at information about patients with specific medical needs, so long as the PHI they review does not leave BCM.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to law enforcement in order to help prevent the threat.

Armed Forces and Foreign Military Personnel. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose your PHI to authorized federal officials so they may provide protection to the President of the United States, other authorized persons or foreign heads of state, or to conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official under specific circumstances such as (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

When Your Authorization is Required

Uses or disclosures of your PHI for other purposes or activities not listed above will be made only with your written authorization (permission). If you provide us authorization to use or disclose your PHI, you may revoke your authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by your written permission. However, we are unable to take back any disclosures we have already made with your permission.

An authorization form is available from your health care provider or by calling the BCM Compliance Office. See last page for contact information.

Special Protections for Alcohol and Drug Abuse Information

Alcohol and drug abuse information has special privacy protections. BCM will not disclose or provide any PHI relating to the patient's substance abuse treatment unless: (1) there is a patient authorization; (2) a court order requires disclosure of the information; (3) medical personnel need the information to meet a medical emergency; (4) qualified personnel use the information for the purpose of conducting scientific research, management audits, financial audits or program evaluation; or (5) it is necessary to report a crime or a threat to commit a crime, or to report abuse or neglect as required by law.

Your Rights

You have the following rights regarding the PHI we maintain about you.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. We are not required to agree with your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. BCM will notify you in writing whether we agree or do not agree with your request. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit BCM's use and/or disclosure of the information; (3) to whom you want the limits to apply (for example, disclosures to your spouse); and (4) your contact address. A restriction request form is available electronically at http://www.bcm.edu/compliance/hipaa. See last page for other contact information.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by telephone at work or that we only contact you by mail at home. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Inspect and Receive a Copy. You have the right to inspect and receive a copy of PHI that may be used to make decisions about your care. Usually, this includes medical and billing records. Psychotherapy notes may not be inspected or copied. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect or receive a copy in certain very limited circumstances. If you are denied access to PHI, we will notify you in writing, and you may request that the denial be reviewed. Another licensed health care professional chosen by BCM will review your request and the denial. The

person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you believe that PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for BCM. You must include a reason that supports your request. In order to ensure that we collect the information we need, BCM provides a form electronically at http://www.bcm.edu/compliance/hipaa. See below for other contact information.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the PHI kept by or for BCM; (3) is not part of the information that you would be permitted to inspect and copy; or (4) is accurate and complete. BCM will notify you in writing whether we agree or do not agree with your amendment request.

Additionally, if we grant the request, we will make the correction and distribute the correction to those who need it and those you identify that you want to receive the corrected information. If we deny your request for an amendment, we will notify you how you may file a complaint with BCM or the Department of Health and Human Services.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" that have been made by BCM in the past six (6) years. The accounting (or list) of disclosures will include: (1) the date of the disclosure; (2) the name of the entity or person who received the PHI and, if known, the address; (3) a brief description of the PHI disclosed; and (4) a brief statement of the purpose of the disclosure. Your request must state a time period not longer than six (6) years and may not include dates before April 14, 2003. The first list you request within a twelve (12) month period will be free of charge. For additional lists, we will charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy, contact the BCM Compliance Office. See below for contact information.

Access to Electronic Copy of This Notice. You may obtain an electronic copy of this notice at our web site, http://www.bcm.edu/about/privacy/notices.cfm.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on BCM premises, and on BCM's web site. The notice will contain on the first page, in the lower right-hand corner, the effective date. In addition, each time you register at or are admitted to BCM for treatment or health care services as an inpatient or outpatient, you may request a copy of the current notice in effect.

For More Information, Requests Related to Your Rights, or to Report a Problem

If you have questions regarding your rights, would like additional information, would like to report a problem, or believe your privacy rights have been violated, please contact one of the following:

BCM Compliance Office
Two Greenway Plaza, Suite 910
Houston, Texas 77049
713-798-8377

Compliance Help Line
713-961-3547

BCM HIPAA Privacy Officer
713-798-5637

You may also write to the Office for Civil Rights for any privacy rights violation. There will be no retaliation for filing a complaint.

Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street, Suite 1169
Dallas, Texas 75202

BCM
Baylor College of Medicine

Acknowledgment of Receipt of Privacy Notice

By signing this form, you are agreeing that you have received a copy of the Baylor College of Medicine Privacy Notice, which describes how we use and disclose your health information. You have the right to refuse to sign this Acknowledgment, in which case we must document our good faith effort to obtain your acknowledgment and the reason why it was not obtained.

Receipt of Privacy Notice acknowledged by:

Signature

Print name (Please print clearly)

Date

BCM ID# (Use DOB, if you do not know your ID#)

Relationship to patient/employee:

☐ Self ☐ Other: _____

Patient, spouse, legal representative, or beneficiary (Patient's spouse may authorize disclosure of patient's health information only when the health information is for the sole purpose of processing an application for health insurance, for enrollment in a health care service plan or an employee benefit plan, and where patient is to be an enrolled spouse or dependent under the policy or plan).

How to Use the PIT Application Submission Spreadsheet

1. Please download and save the PIT Application Submission Spreadsheet. You will only have to do this once. If you are unfamiliar with downloading and saving, here's how to do it:
   a. Double-click on the attachment open the PIT Application Submission Spreadsheet.
   b. Click on File, then on Save As.
   c. In the Save As box, select the appropriate location for saving the file.
   d. Leave the file and file type as already appears in the dialog box.
   e. Close the saved PIT Application Submission Spreadsheet.

2. When ready for use, open the PIT Application Submission Spreadsheet, choose File, Save As and name it with today's date. (Submit no more than one PIT Application Submission Spreadsheet each day.)

   Note: Data on this PIT Application Submission Spreadsheet will be used by TMB to match with a PIT applicant's online submission, so be very careful that your data entry is correct. Please advise your applicants to do the same. If matches between an applicant's online submission of his or her TMB ID number, Program ID number and either SSN or ECFMG number to the same fields submitted in your PIT Application Submission Spreadsheet, there will be delays in processing that application.

3. You're ready to begin data entry.
   a. You will see 12 columns for the different data fields to be collected (see the sample screen at the end of the instructions).
   b. You will enter a row of information for each applicant, with the data for each applicant in the appropriate column.
   c. Click on cell A2 to begin data entry.
   d. You may move to the next column on the same row by using the TAB key.
   e. Start a new row for each applicant.
   f. Information about each column of data is shown below.

   ACGME, AOA or TMB Program ID #
   - Enter the numeric code for the specific program.
   - Do not enter the dashes – only numbers; the dashes will display after entry.
   - Please call if you have any questions – using an incorrect Program ID will significantly delay the process of issuing a permit.

   PIT Type
   - This column contains a drop down list and you must select PIT, ROT or CP.
     PIT = Initial PIT Permit
     ROT = Rotator Permit (Initial and Subsequent)
     CP = Institution Change PIT Permit (use if a PIT applicant has had a PIT permit at another institution and is now joining your institution)

   Note: PIT holders changing programs **within** the same institution do **not** need to apply for a new PIT permit. Send TMB an e-mail to pits@tmb.state.tx.us with the new Program ID and any changes to the begin and end program dates.

   TMB personal ID #
   - If the PIT applicant has ever had any kind of application, permit or license with TMB, the applicant should already be assigned a TMB personal ID number in our system.
   - Please make every effort to enter this number, if it exists, to avoid duplication in TMB's system and delay in issuing the permit.

   First/Middle Name
   - Enter the first and middle names of the PIT applicant.
   - This name field may ultimately be overwritten if the PIT applicant supplies a variation of the name when applying online. However, it will be useful to TMB in the event that other fields don't match as expected.

Last Name
- Enter the last name of the PIT applicant.
- This name field may ultimately be overwritten if the PIT applicant supplies a variation of the name when applying online. However, it will be useful to TMB in the event that other fields don't match as expected.

Suffix
- This column contains a drop down list and you may select JR, SR, II, III, IV or V.
- Leave the cell blank if an applicant has no suffix on his or her name.

Degree
- This column contains a drop down list and you must select either MD or DO.

SSN
- Enter the PIT applicant's social security number, if one exists.
- Do not enter dashes – only numbers; the dashes will display after entry.

ECFMG #
- If the PIT applicant is an international medical graduate, enter the applicant's ECFMG number.
- Do not enter dashes – only numbers (in this case the dashes will not display after entry).

Training Program Start Date
- Enter the date the applicant will start the training program.
- Use slashes (/) and the format mm/dd/yy. An example is 7/1/05.

Training Program Completion Date
- Enter the date the applicant is scheduled to complete the training program.
- Use slashes (/) and the format mm/dd/yy. An example is 6/30/08.

H1B Visa Letter Needed?
- Select Yes from the drop down list if an INS letter is needed. If not, skip this cell.
- If Yes is entered in this column, an INS letter will be included with the initial correspondence sent by TMB.

4. Click the Save icon or File/Save periodically while working on your PIT Application Submission Spreadsheet.

5. After you have entered a row of data for each applicant, save the PIT Application Submission Spreadsheet one last time and close it.

6. Send the PIT Application Submission Spreadsheet to the TMB at pits@tmb.state.tx.us as an attachment.

7. Requirements for acceptance of the PIT Application Submission Spreadsheet:
   a. The e-mail should come from the director of medical education, the chair of graduate medical education, the program director, or (if none of the previously named positions is held by a physician) the supervising physician of the postgraduate training program.
   b. We will also accept the spreadsheet in an e-mail from a staff member, so long as the director of medical education, chair of graduate medical education, the program director, or, if none of the previously named positions is held by a physician, the supervising physician of the postgraduate training program is copied on the email and the appropriate selection is indicated in the certification.
   c. In the body of the e-mail, the following certification statement must be included:

      I, **(insert name here)**, certify that I am **(delete those that do not apply)**
      - __ the chair of graduate medical education
      - __ the program director
      - __ if none of the previously named positions is held by a physician, the supervising physician of the postgraduate training program, or
      - __ the **(Housestaff Coordinator or appropriate title)**, that I am acting on behalf of **(insert name here)** who is the **(chair of graduate medical education/program director/supervising**

physician), and that the named individual has authorized me to make the following certification. I am sending a copy of this e-mail to the named individual.

This information is submitted for **(insert name of program).**

I certify that:

- the program meets the definition of an approved postgraduate training program outlined in Board Rule 171.3 (a)(2) and (3);
- the applicant(s) listed on the attached PIT Applicant Submission Spreadsheet have been credentialed by the program to include verification of identity, and verification of medical school graduation;
- the applicants listed on the PIT Applicant Submission Spreadsheet have met all educational and character requirements established by the program and have been accepted into the program;
- the program has received a letter from the dean of each applicant's medical school which states that the applicant is scheduled to graduate from medical school before the date the applicant plans to begin postgraduate training, if the applicant has not yet graduated from medical school.

Sample PIT Application Submission Spreadsheet