Harbor-UCLA
MEDICAL CENTER

Harbor-UCLA Medical Center

Release of Information Consent

I, (Last Name, First Name, Middle Name.)_____,
consent to the release of information concerning my medical school training and graduation, all previous post-graduate training, current and previous state licensure, and letters of recommendation to Harbor-UCLA Medical Center located in Torrance, California.

I release from any and all liability the Harbor-UCLA Medical Center and its representatives for their acts performed in good faith and without malice in connection with evaluating my credentials to be a House Staff Member at Harbor-UCLA Medical Center.

_____ _____

Signature Date

Last Name, First Name, Middle Name: _____

Official Data Sheet and Application for Resident or Fellow

County of Los Angeles
Harbor-UCLA Medical Center

1. **Name** _____
   Last First Middle
2. **Address** _____
3. **City, State, Zip** _____
4. **Phone** _____ **Social Security** _____
5. **Email Address** _____ **Ethnic Origin**
6. **Birth date** _____ **Sex** _____ **U.S. Citizen**? _____
7. **Application is being made for** _____
   (1st yr, 2nd yr, 3rd yr, etc.)
   a. Residency/Fellowship in _____
8. **Starting Date** _____
9. **Projected Completion Date** _____
10. **Undergraduate Training**:
    a. Name of School and Dates Attended _____
11. **Medical School:**
    a. Name of School and Dates Attended _____
12. **Degrees** _____ _____
13. **Previous Residency/Fellowship Training** (if applicable):

	Dates Attended	Name of Hospital or School	Address
1st year			
2nd year			
3rd year			
4th year			

13. **California Medical License #** (if applicable) _____ Exp Date _____

14. **DEA # & Exp Date** _____

15. **Beeper #** _____ **Physician ID #** _____

16. **ACLS Certification** _____ **Exp Date** _____

17. **Visa Status/INS #** _____ **ECFMG Certificate** _____

18. **Marital Status** _____ **Spouse's Name** _____

19. **For Emergency Purposes: Please Provide Name, Address, Email and Telephone Number of Parents or Nearest Relative:**

_____
_____
_____
_____

Certificate of Applicant
(Read this statement carefully before signing)

I hereby certify that all statements made on or in connection with this application, are true and complete to the best of my knowledge and belief, and I understand and agree that any misstatements or omissions of material fact herein may cause forfeiture on my part of all rights of employment by the County of Los Angeles or by any district served by the County of Los Angeles Department of Human Resources.

_____

Signature of Applicant Date

List any name(s) you have ever used other than the one signed above (maiden name, previous married name(s), etc.)

_____

_____

HARBOR-UCLA MEDICAL CENTER

RESIDENT AGREEMENT
REGARDING MEDICAL RECORDS AND RADIOLOGY FILMS

I agree to complete all medical charts in a timely manner. I understand that my obligations may include, but may not be limited to admission history and psychical examination notes, progress notes, orders, operative reports, and written and dictated discharge summaries. Failure to complete these notes in a timely manner may negatively impact patient care and hospital resources.

I also agree to return all patient charts and films to the Medical Records and Radiology Departments in a timely manner and not sequester either the charts or films. Sequestering charts and films may also negatively impact patient care.

I understand that failure to comply with these regulations in a consistent manner may result in disciplinary action being brought against me, and that my medical record deficiencies will be documented in my permanent file, and conveyed to future employees and/or medical staff offices, including hospital privileges committees.

Last Name, First Name, Middle Name	Signature	Date

Harbor-UCLA
MEDICAL CENTER

Delvecchio Finley, MPP, FACHE
Chief Executive Officer

Timothy L. Van Natta, MD, FACS
Interim Chief Medical Officer

Kim McKenzie, RN, MSN
Chief Nursing Officer
Chief Operational Officer

Graduate Medical Education

Darrell W. Harrington, M.D.
Director and Designated
Institutional Official
310-222-2903

Melissa Moncada
Administrative Director
310-222-2911

www.Harbor-UCLA.org
1000 West Carson Street, Box 2
Torrance, CA 90509
Tel: (310) 222- 2911
Fax: (310) 782-8599

OFFICE OF GRADUATE MEDICAL EDUCATION

March 2014

Dear Physician Postgraduate:

California Physicians and Surgeons license requirements apply as follows:

US Medical School Graduates

- A resident physician who has completed an internship (first postgraduate year training) must meet all requirements determined by the Medical Board of California and must apply for licensure during his/her second year of training and be fully licensed by the end of the second year prior to continuing in the third year of the training program.
  - *Harbor-UCLA hospital policy requires trainees to be fully licensed by December 31st of the second year of training.*
- **If you have not received training in an approved program elsewhere prior to your commencement of first postgraduate year training at the Harbor-UCLA Medical Center, you must obtain a license by December 31, 2014.**
- **A resident physician entering a Harbor-UCLA training program, who has had two or more years of training, must have a license upon arrival.**

International Medical School Graduates (IMG)

- International Medical Graduates (IMG) must complete two years of training in the U.S. to be eligible for a California Physicians and Surgeons license. Any training received in an approved program in the U.S. is counted toward this requirement. IMG's must be fully licensed by the end of their third year of training.
- **An IMG resident physician entering a Harbor-UCLA training program who has had 3 or more years of training must have a license upon arrival.**

If you have received **any** training in an approved program elsewhere, please contact Melissa Moncada in the GME Office immediately. Please review the *Important Licensure Information* on the reverse.

Sincerely,

Darrell W. Harrington, M.D., F.A.C.P.
Associate Medical Director and Director of Medical Education

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT

Last Name, First Name, Middle Name Signature Date

☐ **I HAVE MY CALIFORNIA PHYSICIANS & SURGEONS LICENSE. THE NUMBER IS _____ EXP._____**

IMPORTANT LICENSURE INFORMATION

California Medical Licensure

The Medical Board of California requires that residents who have had 24 months of training and are continuing in California be licensed by the first day of their 25th month of training no matter what year level of training he/she is entering. International Graduates have until the end of the 36th month of training, no matter what year level of training he/she is entering, to become licensed. Any resident failing to meet that requirement will be subject to termination from their program.

Harbor-UCLA Medical Center requires that residents must be familiar with the requirements for licensure by the Medical Board of California and apply for and receive a valid license by December 31 of the GY-2 year no matter what year level of training he/she is in. International medical graduates must fulfill similar requirements by the end of the GY-3 year. Once received, the resident is responsible for maintaining a current valid license for the duration of postgraduate training. Failure to be licensed as described above may cause an interruption in the continuation of training and suspension of employment without pay until a valid license has been obtained or the resident's employment is terminated at the discretion of the program director.

Drug Enforcement Administration (DEA) Registration

Unless the Medical Center's Medical Director issues specific written exemption, licensed residents are required to obtain and use their assigned DEA registration number. A copy of this DEA certificate must be on file in the Office of Graduate Medical Education and the appropriate departmental office. Effective July 1, 1996, all residents (GY-3 and above) must present documentation that they have applied for or possess a current DEA registration. Failure to do so will result in suspension of employment without pay until the deficiency is corrected. The GME Office can exempt the fee of your DEA. Please find instructions at www.harbor-ucla.org/licensure.php

Health Services

PRIVACY & SECURITY SURVIVAL TRAINING: PROTECTING PATIENT PRIVACY

ANSWER SHEET AND PROOF OF COMPLETION

Instructions: Please circle the correct letter corresponding with the questions in the study guide. You must score 20 correct to receive credit for Mandatory Training.

1.	☐A	☐B	☐C	☐D	☐E	11.	☐A	☐B	☐C	☐D	☐E
2.	☐A	☐B	☐C	☐D	☐E	12.	☐A	☐B	☐C	☐D	☐E
3.	☐A	☐B	☐C	☐D	☐E	13.	☐A	☐B	☐C	☐D	☐E
4.	☐A	☐B	☐C	☐D	☐E	14.	☐A	☐B	☐C	☐D	☐E
5.	☐A	☐B	☐C	☐D	☐E	15.	☐A	☐B	☐C	☐D	☐E
6.	☐A	☐B	☐C	☐D	☐E	16.	☐A	☐B	☐C	☐D	☐E
7.	☐A	☐B	☐C	☐D	☐E	17.	☐A	☐B	☐C	☐D	☐E
8.	☐A	☐B	☐C	☐D	☐E	18.	☐A	☐B	☐C	☐D	☐E
9.	☐A	☐B	☐C	☐D	☐E	19.	☐A	☐B	☐C	☐D	☐E
10.	☐A	☐B	☐C	☐D	☐E	20.	☐A	☐B	☐C	☐D	☐E

PLEASE PRINT LEGIBLY

LAST NAME, FIRST NAME, MIDDLE NAME			EMPLOYEE/ID NO.
JOB CLASSIFICATION	ITEM NO.	DEPARTMENT NAME	P/L
WORKFORCE MEMBER SIGNATURE			DATE
☐ **Check here if non-DHS/non-County Workforce Member**	EMPLOYER NAME		PHONE NO.

I attest I have read the Privacy & Security Survival Training: Protecting Patient Privacy Study Guide and am familiar with the contents and will abide by the guidelines set forth.

If I have any questions or concerns, I will talk to my supervisor or the facility Privacy or Information Security Coordinator.

PROGRAM DIRECTOR NAME	PROGRAM DIRECTOR SIGNATURE	DATE

Distribution: Original - Area File Copy - Facility Human Resources

PRIVACY & SECURITY SURVIVAL TRAINING: PROTECTING PATIENT PRIVACY
ASSESSMENT QUESTIONS

1. As a workforce member of this facility, you may access a patient's protected health information:

   a. whenever you want to do so
   b. if your co-worker or supervisor asks you to do so
   c. only if your job duties require you to do so
   d. in an emergency even if you're not authorized

2. It is your responsibility to immediately report any suspected privacy or security breach, such as any theft of computer equipment or unauthorized or inappropriate access, use, disclosure, or destruction of patient or confidential information:

   a. True
   b. False

3. Patient or confidential information should not be viewed, accessed, or disclosed without a need to know. Which of the following forms of confidential information would be protected under HIPAA?

   a. A paper-to-paper fax
   b. Verbal conversations
   c. Information written solely on paper
   d. All of the above

4. You only need to contact your facility Information Technology Help Desk to obtain authorization to e-mail PHI.

   a. True
   b. False

5. If you are only going to be away from your desk for a few minutes you do not need to lock or log off your workstation.

   a. True
   b. False

6. Jason's supervisor wants access to his computer when he is away from the office. The supervisor has a right to know his username and password.

   a. True
   b. False

7. DHS may log, review, or monitor any data you have created, stored, sent, or received using County Information Systems (e.g., computer, laptop, etc.).

   a. True
   b. False

8. What is the Notice of Privacy Practices (NPP)?

   a. It is a tool to enable patients to express their concerns about misuse of PHI
   b. It informs the patient of services the facility does not provide
   c. It is a tool that allows patients to select the type of information that they would like to have sent back to their provider
   d. It describes patient rights and the provider's responsibilities regarding PHI

9. Which of the following are authorized to release patient information when requested by a patient, law enforcement, etc.?

   a. Physicians
   b. Nursing staff
   c. Health Information Management staff
   d. Employee Health Services staff

10. A password on a portable storage device is sufficient to protect PHI in case of loss or theft of the device.

    a. True
    b. False

11. Which of the following disclosures of PHI is *not* a privacy breach and/or security breach?

    a. Mary has access to the patient information system and decides to check her health records to see what is in it
    b. Walter works in HIM and provided a patient's medical information to the United States Department of Health and Human Services
    c. Janice, a law enforcement officer, is friends with the hospital receptionist and asks her to look up her ex-husband's records to check which medicines were prescribed at his last visit
    d. All are allowable under HIPAA

12. Mary has been out sick. Her supervisor finds out from their Human Resources Return-to-Work Unit that Mary has cancer, and tells Mary's coworkers about it. It is okay for Mary's supervisor to let her coworkers know about Mary's cancer since the coworkers all care about her well-being.

    a. True
    b. False

13. You may be subject to fines and penalties under State and federal laws and/or disciplinary action if you fail to comply with patient privacy laws or County, DHS, or facility policies and procedures.

    a. True
    b. False

14. If the State determines you have violated the State privacy laws, they may report you to the appropriate licensing, registration, certification, or permit board/agency for possible disciplinary action.

    a. True
    b. False

15. A patient or individual can report a suspected privacy or security breach to the following entities:

    a. Supervisor
    b. Facility Privacy Coordinator or Information Security Coordinator
    c. County Fraud Hotline
    d. DHS Compliance Hotline
    e. Any of the above

16. There will be no retaliation against a workforce member who, in good faith, reports any actual or suspected privacy breaches or HIPAA violation

    a. True
    b. False

17. In addition to medical records, PHI may be found in written communications, electronic forms, verbal conversations, e-mails and memos, IV and medication labels, X-rays, monitors, EKGs, etc. and must be protected.

    a. True
    b. False

18. While working the 9pm – 6am shift at the hospital, you see some patient information in a trash can. What should you do?

    a. Remove it from the trash can, if safe to do so, and take it to the shredder bin.
    b. Remove it from the trash can, if safe to do so, or secure the trash can and immediately notify your supervisor.
    c. Immediately report it to the facility Chief Financial Officer
    d. Call the toll-free hotline and report it

19. An employee mistakenly receives a fax containing PHI from an outside healthcare agency. What should the employee do?

    a. Contact the person on the cover sheet
    b. Throw the FAX in the shredder bin
    c. Contact the facility Privacy Officer
    d. All of the above

20. When you have a patient's prior written permission to videotape them, it is permissible to use your own video camera.

    a. True
    b. False

PRIVACY & SECURITY SURVIVAL TRAINING: PROTECTING PATIENT INFORMATION

ANSWER KEY:

1. C
2. A
3. D
4. B
5. B
6. B
7. A
8. D
9. C
10. B
11. B
12. B
13. A
14. A
15. E
16. A
17. A
18. B
19. D
20. B

DEPARTMENT OF HEALTH SERVICES
COMPLIANCE AWARENESS TRAINING

CODE OF CONDUCT ACKNOWLEDGEMENT

Instructions: After you have completed the Compliance Awareness Training, please complete this Code of Conduct Acknowledgement and submit it to your supervisor or trainer.

Date:	(Last Name, First Name, Middle Name):	Employee No.:	Department Name:	Pay Location:
		Dept. No.:	Work Area:	Phone No.:

I acknowledge that I have received the Department of Health Services' Code of Conduct and completed the Compliance Awareness Training. I agree to abide by the Code of Conduct as it relates to my job responsibilities. I understand that non-compliance with the Code of Conduct can subject me to disciplinary action up to and including discharge from service.

SIGNATURE _____

DATE _____

c: Workforce Member
Unit File
Official Personnel/Contractor File

Health Services
LOS ANGELES COUNTY

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES

Notice and Acknowledgement of Code of Conduct

I understand it is the policy of Los Angeles County that all Workforce Members (defined as County employees and/or Non-County contractors, students, agency personnel, volunteers, whether they are permanent, temporary, part-time, or other) are personally responsible for compliance with the Department of Health Services Code of Conduct.

ACKNOWLEDGEMENT

By my signature below, I acknowledge and affirm each of the following:

1. I have received a copy of the County of Los Angeles Department of Health Services Code of Conduct publication.

2. I shall be held personally responsible and accountable for complying with the standards as set forth in the Code.

3. If I violate any provisions of the Code, I will be subject to disciplinary action, which may include discharge from County service, and/or agency.

4. I will complete the Compliance Awareness Training (which includes the Code of Conduct) within 30 days of signing this acknowledgment. I understand that the training is available via the computer-based training on the DHS Home Page, **Harbor Intranet** or by using the Self-Study Guide.

5. I will submit my Code of Conduct/Compliance Awareness Acknowledgement and Certificate upon completion of the Training to my supervisor who will forward to:

    a. Human Resources (County employees) for filing in my Official Personnel File, **or**
    b. Area Contract Monitor (Non-County Workforce for my Division Area File.

Name (Print):	Employee # or Name of Agency/Affiliation: HARBOR-UCLA MEDICAL CENTER	Date:
Signature:	Job Title (Print):	Pay Location:
Human Resources Rep. (Print):	Human Resources Rep. Signature:	Date:

Distribution: Original – Human Resources Official Personnel File (County Employees)
Duplicate – Retained in Departmental Area File – County and Non-County Workforce Members, Contractors, Students, Volunteers, and Agency Personnel

Revised 3/7/12

COMPLIANCE AWARENESS TRAINING

ASSESSMENT ANSWER SHEET

Date:	Last Name, First Name, Middle Name:	Employee No.:	Department Name:	Pay Location:
		Dept. No.:	Work Area:	Phone No.:

Instructions: Please check the best answer.

1. a ☐ b ☐
2. a ☐ b ☐
3. a ☐ b ☐ c ☐ d ☐
4. a ☐ b ☐ c ☐ d ☐ e ☐
5. a ☐ b ☐
6. a ☐ b ☐ c ☐ d ☐
7. a ☐ b ☐
8. a ☐ b ☐ c ☐ d ☐ e ☐
9. a ☐ b ☐ c ☐ d ☐
10. a ☐ b ☐
11. a ☐ b ☐
12. a ☐ b ☐
13. a ☐ b ☐
14. a ☐ b ☐ c ☐ d ☐
15. a ☐ b ☐

YOU ARE DONE!

Please turn in this Assessment Answer Sheet and your signed Code of Conduct Acknowledgement to your supervisor/manager.

Compliance Awareness Training
Los Angeles County Department of Health Services

Choose the correct answer by circling the corresponding letter on your answer sheet.

1. The overall goal of the DHS Compliance Program is compliance with all applicable laws, regulations, and other standards that govern the conduct of healthcare organizations and governmental entities.
a. True
b. False

2. The Code of Conduct provides detailed information on all DHS policies; therefore, it is not necessary to refer to other DHS/ facility policies or procedures.
a. True
b. False

3. You must report:
a. Only conduct that you are sure is inappropriate
b. Only conduct that you suspect to be illegal
c. Conduct that you suspect is illegal or in violation of a DHS/facility policy
d. Only conduct that could result in a loss of County funds

4. You should discuss suspected misconduct with:
a. Your supervisor
b. Your Local Compliance Officer
c. The DHS Compliance Hotline
d. The County Fraud Hotline
e. Any of the above

5. Only DHS employees are required to follow the Code of Conduct.
a. True
b. False

6. If you report suspected misconduct:
a. Your supervisor can transfer you out of the unit to a less desirable position
b. You are protected by federal and State law if you file a whistleblower lawsuit
c. You are protected from retaliation by the County
d. Both B and C

7. The federal False Claims Act prohibits creating inaccurate documents to support a claim to the federal government for payment.
a. True
b. False

8. DHS' goal is to ensure that all claims for reimbursement:
a. Are accurate
b. Conform to the applicable Federal and State laws and regulations
c. Contain information in all required fields, regardless of whether we know that the information is correct
d. Both A and B
e. All of the above

9. It is appropriate to falsify DHS documents when:
a. You need to meet a deadline
b. Your boss asks you to
c. You are unsure of the correct information
d. It is never appropriate to falsify DHS documents

10. If you are required to have a professional license, certification or credential to do your job, you are responsible for making sure it is kept active and current.
a. True
b. False

11. If your family member owns a company that DHS is considering doing business with, you may participate in the decision of whether or not to do business with this company.
a. True
b. False

12. Federal and State anti-kickback laws strictly prohibit payments that are intended to encourage the referral of patients.
a. True
b. False

13. The selection of contractors/vendors is made based on technical excellence, price, service, and personal relationships.
a. True
b. False

14. You may accept certain gifts from individuals or organizations that have a business relationship with DHS, such as:

a. Gift certificates
b. Ticket to a sporting event
c. A box of candy intended for the work unit
d. Trips

15. You should only answer the specific questions asked by an auditor/investigator and not provide any additional information that would make your response more accurate.

a. True
b. False

YOU ARE DONE!
Please turn in your answer sheet and signed Code of Conduct Acknowledgement to your Program Coordinator.

COMPLIANCE AWARENESS TRAINING

ASSESSMENT ANSWER KEY

1. a
2. b
3. c
4. e
5. b
6. d
7. a
8. d
9. d
10. a
11. b
12. a
13. b
14. c
15. b