Crozer Chester Medical Center
Department of Surgery- Contact Information

Name

Home Address 1

City

State

Home Phone

Cell Phone

Pager Number

Crozer Pager Number

Medical License #

Medical License
☐ Temporary ☐ Permanent

Date Medical License Issued

Medical License Expiration Date

ECFMG
☐ Yes ☐ No

Issue Date
☐ N/A

ATLS expiration Date

ACLS expiration Date

Print Signature

Electronic Signature

Date

Department of Surgery
Surgical Resident and Student
Pager Responsibility Agreement

☐Residents or ☐Students on Surgical Rotations at ☐ Crozer ☐ Taylor ☐ DCMH campuses should go to the telecommunications office on the ground floor to sign for and pick up their assigned pagers. At the end of the rotation, the pager should be returned to the telecommunications office at Crozer. Failure to follow this process may result in a charge of $350 for lost pagers which are not able to be located, whether lost, stolen or misplaced.

Pagers damaged should be taken to telecommunications for replacement.

Note:

All pagers have a built in identifier which is logged in at telecommunications and assigned a hospital specific pager number. If the built in number of a returned pager does not match the numbers on record in telecommunications, the pager will be taken and after investigation, a fee of $350 will be assessed to the risible resident or student through their sponsoring education program.

Should anyone leave pagers in a call room or hand off the pager to an incoming resident or student, the incoming resident or student must go to telecommunications and sign for receipt of the pager. If the pager is lost or misplaced, the last person name on the telecommunications log for that pager will be held responsible for the lost pager fee.

I have read the pager responsibility Agreement and by my signature below, accept responsibility for the safe return of my assigned pager.

Pager Number

Dates of rotation

Print Signature

Electronic Signature

Date

OIG Sanction Check

☐ Resident
☐ Student

Print Signature

Department
Surgery

Date of Birth

Please forward this page- ONLY this page to Mary Ellen Orner, MaryEllen.Orner@crozer.org- for review of sanction status. Once checked, she will return the verification form to your Department.

Physician Statement

I acknowledge receipt of Crozer-Keystones Corporate Integrity Program summary, and I have read and understand and agree to comply with the Code of Conduct contained in that summary.

Department

Surgery

Entity

- ☐ Crozer Chester Medical Center (CCMC)
- ☐ Community Hospital
- ☐ Taylor Hospital (TH)
- ☐ Springfield Hospital (SH)
- ☐ Healthplex-Springfield
- ☐ Delaware County Memorial Hospital (DCMH)
- ☐ Crozer Keystone Health System (CKHS)
- ☐ Crozer-Keystone Health Network (CKHN)

Print Signature

Electronic Signature

Date

Fire/Safety and Compliance

I acknowledge receipt of Student resident orientation program for Fire/Safety and Compliance, and I have read and understand and agree to the contents.

Department

Surgery

Entity

- ☐ Crozer Chester Medical Center (CCMC)
- ☐ Community Hospital
- ☐ Taylor Hospital (TH)
- ☐ Springfield Hospital (SH)
- ☐ Healthplex-Springfield
- ☐ Delaware County Memorial Hospital (DCMH)
- ☐ Crozer Keystone Health System (CKHS)
- ☐ Crozer-Keystone Health Network (CKHN)

Print Signature

Electronic Signature

Date

Restraint and Seclusion Policy

I acknowledge receipt of the restraint/seclusion policy (effective date 1/1/01 Revised 5/02). I have read and understand the policy. A copy of this signature sheet will be sent to the Quality Monitoring and Improvement/Patient Safety Officer.

Department

Surgery

☐ Resident
☐ Student

Print Signature

Electronic Signature

Date

Access and Confidentiality Agreement

As a resident or student within the Crozer Keystone Health System ("CKHS") you may have access to "confidential information". The CKHS corporate Integrity Program requires that you protect and keep confidential, all patient medical records and information. Information about a patient's condition, care, treatment. Personal affairs or records, other than the patient's general condition, is to be discussed only with authorized family members, the attending physician, facility management and other employees whose assignments make access to such information necessary for the care and treatment of the patient or reimbursement for the patients care. The purpose of this agreement is to help you understand your duties regarding confidential information.

You may learn of or have access to some or all of this confidential information through medical records, billing records, voicemail, correspondence, a computer system, and other training activities. Confidential information is valuable and sensitive and is protected by law and by strict CKHS policies. The intent of these laws and policies is to ensure that confidential information remains confidential. As a student/intern/resident, you are required to conduct yourself in strict conformance to applicable laws and CKHS policies governing confidential information. The violation of any of these policies will subject you to discipline, which may include termination of your participation in the training program and legal liability.

1. You will use confidential information only as needed to perform your legitimate duties as a student/intern/resident affiliated with CKHS. This means, among other things, that:

    a. You will only access confidential information for which you have a training related need to know and you will not disclose any confidential information outside of the appropriate scope of your training program.

    b. You will protect confidential information

    c. You will not copy, release, review, alter or destroy any confidential information except as properly authorized within the scope of your training related activities.

    d. You will participate and complete training in CKHS privacy and security policies and procedures.

2. You will not disclose any access code or password that permits you to review confidential information. You accept responsibility for all activities undertaken using your access code and other authorization.

3. You will report activities by an individual or entity that you suspect may have violated CKHS confidentiality/privacy/security policies. A telephone helpline at 188-387-7921 is available for those who wish to remain anonymous.

4. You understand that your obligations under this agreement will continue after you have completed your training at CKHS.

5. You understand that you have no right or ownership interest in confidential information referred to in this agreement.

6. When your training ends, you will cease using passwords and return to your supervisor all identification cards or other means of access to confidential information or areas.

Your signature below indicated your understand and agreement.

Department

Surgery

☐ Resident
☐ Student

Print Signature

Electronic Signature

Date