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.

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**
- **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 with a crime or offense (felony or misdemeanor):
   a. related to the delivery of or billing for health care services under the Medicare or Medicaid program? Yes No

Name _____
Please PRINT

b. related to the abuse or neglect of patients in connection with the delivery of health care? Yes No
c. 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. related to the obstruction of justice? Yes No
e. 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 you ever been the subject of any adverse professional actions (including but not limited to a denial, revocation or suspension of your medical staff membership and clinical privileges) or other disciplinary actions (including but not limited to formal written warnings, reprimands or probation) 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 System (YNHHS)
Privacy & Security Requirements for Medical & Affiliated Medical Staff

Release and Disclosure of Protected Health Information - A patient's written authorization, valid subpoena, court order, or other authorized documentation will generally be required for any releases, access and/or disclosures of Protected Health Information (PHI) or ePHI (electronic PHI) for non-TPO (treatment, payment, and health care operations) purposes. Additional information and exceptions are outlined in relevant YNHHS policies.

- Visitors should politely be asked to leave before discussing a patient's condition and/or treatment. The choice is then left up to the patient to voice whether the visitors should stay.
- Before sharing PHI with an unknown individual claiming to be a family member, confirm that the patient has not placed restrictions on the release of his/her information. Good faith efforts should be made to verify the identity of the requestor. Information released regarding the patient is required to be restricted to the "minimum necessary".

"Minimum Necessary" - The YNHHS policy is that the disclosure, access and use of protected health information (PHI) will be kept to the minimum amount necessary to carry out duties.

- Healthcare professionals may access the PHI of any patient for whom they are assigned care; other staff will be granted access based on their roles and job functions.
- Only the minimum necessary amount of PHI should be disclosed or requested when disclosing PHI to other entities or requesting PHI from other entities.

E-Mail and Electronic Messaging - Given that the electronic information can be easily intercepted if not appropriately secured, transmission and/or storage of PHI AND OTHER SENSITIVE INFORMATION is NOT PERMITTED using email or messaging solutions that do not meet the Security Rule requirements.

- Email between YNHHS and its affiliated organizations and Yale University is permitted when using an email application approved by YNHHS/University ITS for use with ePHI and other confidential data, such as YU Exchange/Outlook email.
- Do not put PHI in the "Subject" field of an email message.
- YNHHS employees should only use ITS secured devices to exchange email via smartphones, iPads or other portable electronic devices. For the University, email containing PHI may only be sent with a device that has been secured in compliance with Yale University's security policies and procedures.
- Encrypted YNHHS Exchange/Outlook email containing PHI and other sensitive information *may* be sent to approved external email addresses only with the approval of the sender's Vice President for YNHHS employees, and it must be manually encrypted by typing the word '**encrypt**' in the subject field (there must be a space between the word encrypt and any other characters in the subject). See more detailed instructions in the YNHHS Electronic Mail and Electronic Messaging Policy. For medical staff not required to use YNHHS or Yale University secured devices and applications, electronic communication of PHI should be strictly limited to the minimum necessary.
- No electronic messaging (i.e., texting) of ePHI and other confidential data is permitted using devices and applications unless approved by YNHHS/Yale University and in compliance with the Security Rule.

Connecting to the YNHHS Network – All devices used to connect to the YNHHS network must comply with security controls as defined in the Security Rule.

- If you are a YNHHS employee, computing devices other than those provided by a YNHHS hospital may not be connected to the hospital network without prior clearance, in writing, from Information Technology Services (ITS) Office of Information Security. Only devices that meet minimum security requirements including, but not limited to, encryption, current anti-virus, and endpoint protection will be considered for approval. This is to protect the hospital environment from data loss, possible viruses, and other malicious code.
- Yale University devices used to connect to the YNHHS network must be secured as per University HIPAA policy.

YNHHS Notice of Privacy Practices - At first entry to any YNHHS facility, patients will be given the Notice so that they understand how we will use their PHI for the purposes of treatment, payment, and certain health care operations to improve our clinical effectiveness or as otherwise permitted by HIPAA. The Notice will also explain their rights under HIPAA to access their medical record, request an amendment to their record, request an accounting of disclosures, request a restriction or confidential communication, file a complaint, or opt out of our facility directory. Patients will be asked to sign the Notice as an acknowledgement of their understanding.

Presenting at Conferences - All personal identifying information about any patient must be removed from all and handouts used to keep the patient's identity confidential. In addition, please pick up any remaining copies following meetings and make sure that they are disposed of appropriately.

Portable Electronic Devices – All portable computing devices or removable storage devices used to connect to the YNHHS network or store YNHHS ePHI or other confidential data must comply with security controls as defined in the Privacy and Security Rules.

- If you are a YNHHS employee, ePHI that is stored on a portable computing device or removable storage device must be protected with YNHHS ITS-approved encryption, to ensure against disclosure in the event of loss or theft. If you need assistance with encryption please contact the ITS Service Desk (688-HELP) or if a device is lost or stolen, it must be reported immediately to the ITS Service Desk (688-HELP).
- Yale University faculty, staff, trainees, students and members of Yale University'sHIPAA Covered Components must secure any portable computing or removable storage devices as per University policy.

Facsimile (fax) Transmittal - Care must be taken when transmitting PHI via fax. The sender is responsible for verifying the accuracy of the fax number for the intended recipient. Do not rely on fax numbers listed in directories or provided by persons other than the recipient. All faxes must include a cover sheet that includes a confidentiality disclaimer as described in the YNHHS facsimile transmittal policy. The cover sheet for example would include the date/time of transmittal; sender and receiver's name, location, contact information; number of pages; list of transmitted documents; and requested notice to the sender in the event of a transmission error to an unintended recipient and a confidentiality statement.

Appropriate Use of Electronic Resources - Medical & Affiliated Medical Staff members of YNHHS hospitals are required to use electronic resources in a professional, lawful and ethical manner, and to prevent the unauthorized use or disclosure of protected health information or any other confidential information. All Medical & Affiliated Medical Staff members are subject to the same requirements when using YNHHS electronic resources.

Monitoring - YNHHS reserves the right and the authority to monitor the use of YNHHS electronic resources with the exception of phone conversations. Users should have no expectation of privacy in connection with the use of YNHHS resources, systems, equipment, or with the transmission, use or storage of information, including but not limited to stored e-mails or voicemail messages. YNHHS systems, resources and equipment include, but are not limited to, the following: computing devices, E-mail, Voicemail, Telephones, Fax Machines, Pagers, Laptops, Cell Phones, Copiers, PDAs.

User Authentication to Computer Systems - User IDs and their corresponding passwords must be kept confidential and cannot be shared with anyone else. Passwords are not to be stored on your computer or anywhere where they may be found by others. Using someone else's ID and password may result in termination or loss of Medical Staff privileges and disciplinary action up to and including termination if you are an employee. ***Each time you finish using an electronic resource containing PHI or other sensitive data, even for a short period of time - please be certain to log off of the system you are using to minimize the likelihood that an unauthorized user could access records under your name.***

Safeguarding YNHHS PHI and Confidential Information while Working Offsite - YNHHS policies and procedures regarding confidentiality of transporting, storing or accessing PHI are to be followed at all times when working offsite with PHI or other confidential information. Remote users must take reasonable steps to ensure adequate computer virus protection.

Disposal and Control of Documents and Media Containing PHI - When individuals have completed using PHI, media that contains PHI must be stored in a secure location, returned to the authorized owner, or the PHI or the media it is stored upon must be disposed of appropriately. Each type of media/document may require a specific disposal method for example, shredding confidential information.

Storage of PHI and other Sensitive Information – Storage of PHI and other sensitive data must be secured by implementing security controls as set forth in the Security Rule.

- ePHI and other sensitive information obtained in connection with your employment and/or Medical or Affiliated Medical Staff membership may not be saved to the local hard drive on personal computing devices including portable devices. All such data must be saved to the network file server that has been assigned to you by YNHHS ITS.
- Yale University faculty, staff, trainees, students and members of Yale University's HIPAA Covered Components must secure storage of PHI and other sensitive data as per University policy.

Privacy Investigations and Information Security Audit Controls - A suspected privacy violation or privacy complaint regarding inappropriate use, access, or disclosure of protected health information (PHI) will be investigated and appropriate measures taken if any wrong doing is determined. YNHHS facilities reserve the right to record and review audit trails of applications containing PHI, the operating systems and network they run on.

Inappropriate use or disclosure may result in disciplinary action up to and including employment termination and/or removal from the relevant YNHHS hospital Medical Staff or Affiliate Medical Staff.

Privacy Officer - HIPAA related questions and complaints regarding the Hospital or YNHHS facilities should be referred to the Office of Privacy and Corporate Compliance at 688-8416 or privacy@ynhh.org.

HIPAA Security Officer – Please contact the ITS Service Desk (688-HELP) with any HIPAA related security questions or concerns and ask to speak to the Chief Information Security Officer (CISO and HIPAA Security Officer) or one of the Managers from the Office of information Security (OIS).

For more information on privacy and security policies, please see the YNHHS intranet, under the Polices tab, or visit https://ynhh.ellucid.com/manuals/binder/604.

For more information on Yale University privacy and security policies, please visit http://hipaa.yale.edu/.

For more information on privacy and security laws please visit http://www.hhs.gov/ocr/privacy/hipaa/understanding/ Please contact the YNHHS Office of Privacy & Corporate Compliance 203-688-8416 or YNHHS Office of Information Security 203-688-HELP with additional questions.

Reporting Incidents and Violations

You are obligated to report any known or suspected violations of the Privacy or Security Policies as well as the loss or theft of PHI or devices containing PHI. Reports can be made to the Office of Privacy and Corporate Compliance or to the Compliance Hotline.

Compliance Hotline: 888-688-7744 Available 24 hours a day/7 days a week
Office of Privacy and Corporate Compliance: 203-688-8416 or privacy@ynhh.org
Information Security: Contact the ITS Service Desk (203.688-HELP) and ask to speak with the Office of information Security (OIS).

Members of the Medical Staff are responsible for the activity of any of their employees who have been granted access to YNHHS applications & systems (including Epic) and ensuring compliance with the requirements stated in this document.

Privacy and Security Agreement

By signing this document, I certify that I have read and understand the Privacy and Security policies in effect at the Yale New Haven Health System and its affiliated entities' (YNHHS) facilities.

I agree to:

1. Abide by all hospital and YNHHS policies, procedures and guidelines relating to the use, access and protection of Protected Health Information (PHI), as amended from time to time.
2. Hold in strictest confidence all PHI and not to disclose or discuss PHI with any other third party, including friends or family, except as permitted by YNHHS policies, procedures and guidelines and in accordance with state and federal laws *(for additional resources on privacy and security laws please review the attached reference document)*.
3. Use PHI only in connection with the provision of medical care to patients and not remove YNHHS hospital PHI and/or Proprietary Information from any YNHHS premises except as permitted by YNHHS policies, procedures and guidelines and in accordance with state and federal laws.
4. Not discuss PHI where unauthorized persons can overhear the conversation.
5. Report incidents and violations to policies (such as privacy and security concerns witnessed) to the YNHHS Office of Privacy and Corporate Compliance.
6. Ensure that I and any individuals employed by me will abide by Privacy and Security rules and YNHHS policies/procedures.

I understand that:

1. Access to and use of PHI is subject to regular auditing and monitoring.
2. The restrictions described in this Agreement are in force at all times and in all locations.
3. If I fail to comply with the terms of the Agreement, I may be subject to disciplinary action, up to and including termination of my employment (if applicable) and from the Medical Staff.
4. A patient's right to confidentiality of PHI is protected by state and federal laws and YNHHS policies, procedures and guidelines.
5. If I violate this Agreement, I may, as an individual, be subject to civil or criminal legal action for which I will not be provided defense counsel or insurance coverage by YNHHS.
6. My obligations under this Agreement shall survive termination of my employment (if applicable) and Medical Staff membership.
7. Audits are performed and users are responsible for securing and not sharing user names and passwords.

Applicant Full Name (please print):_____

_____ _____

Signature Date

Name _____

Authorization & Release

The terms of this Authorization and Release are applicable to all Yale New Haven Health System affiliated entities (each, a "YNHHS Affiliate").

By requesting an application and/or applying for appointment, reappointment, clinical privileges at, or employment by, one or more YNHHS Affiliates or otherwise in connection with third party payor credentialing matters, I accept and agree to the conditions set forth in this Authorization & Release, (1) regardless of whether appointment, clinical privileges or employment is granted, (2) throughout the term of any appointment or reappointment term or clinical privileges or employment that are granted, (3) even if my appointment or privileges are revoked, reduced, restricted, suspended, or otherwise affected as part of one of the YNHHS Affiliate's professional review activities, and (4) with respect to any communications with third parties before, during or after the term of my appointment, reappointment, clinical privileges or employment.

I understand and agree that acceptance of this application/reappointment application does not constitute approval of membership on the Medical Staff of any YNHHS Affiliate and grants me no rights or privileges of membership until such time as I receive written notice of membership status. I understand that this application will not be processed until all requested information has been received and the application has been deemed complete in accordance with the Medical Staff Bylaws of the relevant YNHHS Affiliate. I understand and agree that it is my responsibility to provide correct and complete information in connection with this application.

OBTAINING INFORMATION FROM ANY THIRD PARTY

I hereby authorize each and all of the YNHHS Affiliates, as well as each of their respective representatives, employees, agents and members, as applicable, to contact and gather information from other YNHHS Affiliates and from third parties, including, but not limited to, my prior associates and anyone else regarding any and all information bearing on my professional competence, character, health status, ethics, ability to work cooperatively with others, or other qualifications.

INFORMATION SHARING

I hereby authorize the YNHHS Affiliates and its authorized employees and representatives to share any and all information bearing on my professional competence, character, health status, ethics, ability to work cooperatively with others, or other qualifications relevant to my medical staff appointment, clinical privileges and/or employment (if applicable), including but not limited to my primary source verification information, peer review information, Ongoing Professional Practice Evaluation ("OPPE") and Focused Professional Practice Evaluation ("FPPE"), application and health information records, including but not limited to demographics, immunization, titer and PPD records and information, obtained during the course of initial appointment, reappointment and/or while I am a medical staff member of and/or employed (if applicable) by such YNHHS Affiliate.

If I am a member of, or applying to be a member of, the Yale Medicine, I consent and agree with the following: I hereby authorize the YNHHS Medical Staff Administration Department to share my appointment and reappointment application(s) with Yale Medicine.

I agree to sign the necessary consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the YNHHS Affiliates as required by the respective Medical Staff Bylaws or other policies relevant to each YNHHS Affiliate.

I agree that the information about me as described above may be shared at any time (not just while my initial or reappointment application is pending) and may be used by the YNHHS Affiliates for Medical Staff credentialing and peer review (as applicable to YNHHS hospitals), health plan credentialing and recredentialing, medical practice group credentialing and recredentialing, and to assist the YNHHS Affiliates in making determinations regarding medical staff membership, privileging and employment (if applicable).

I consent to and authorize YNHHS Affiliates and their representatives, employees and agents to allow the YNHHS Medical Staff Administration Department and accrediting agency or body access to my credentialing and recredentialing files as requested and, further, to permit such organizations, agencies and bodies to review said files to confirm compliance with applicable contracts.

ABIDE BY MEDICAL STAFF BYLAWS

I have read and agree to abide by the Medical Staff Bylaws, Rules & Regulations and relevant policies (which shall include Infection Control, Safety and Standard Precautions, HIPAA Privacy and Security policies, and any policies governing my clinical specialty or workspace) of each of the YNHHS Affiliates (as applicable) and their respective Medical Staffs. I understand that if I have not already received copies of the Medical Staff Bylaws, Rules & Regulations, or policies applicable to my practice at the YNHHS Affiliates, it is incumbent upon me to contact the relevant entity to request a copy of such documents before signing this Authorization & Release.

I agree to provide for continuous care for my patients, to practice in accordance with my clinical privileges as delineated for each YNHHS Affiliate (as applicable) and to obtain consultations as appropriate.

MISREPRESENTATIONS AND OMISSIONS

I declare under penalty of law that all statements, answers, and information contained in or submitted in conjunction with this application are true, correct and complete to the best of my knowledge. I understand that the discovery of any falsification, misrepresentation, or omission of any fact(s) by me will be sufficient cause for the relevant YNHHS Affiliate to cease processing of my application and/or to deem any appointment, privileges, or other credentials previously granted to me to be automatically relinquished, with no hearing or appeal rights. I agree to inform the relevant YNHHS Affiliate(s) in writing, with or without request, within fifteen (15) days, of any changes in the information provided and the answers to questions on the application as a result of new information or developments subsequent to my signing of the application.

Name _____

I agree to defend and indemnify the YNHHS Affiliates, and their representatives, employees, agents and Medical Staff members, for any damages that incur as a result of any false or misleading information provided by me or any material omissions made by me in conjunction with my request for an application, my application for appointment or reappointment, or my application for clinical privileges, or in conjunction with my failure to comply with any provisions of the respective Medical Staff Bylaws, Rules or Regulations, or policies that require me to notify the YNHHS Affiliates about changes to my qualifications that occur during the term of any appointment or clinical privileges granted to me.

IMMUNITY

To the fullest extent permitted by law, I hereby release from liability and agree not to sue all representatives, employees, agents and Medical Staff members of the YNHHS Affiliates for any action, recommendation, report, statement, communication and/or disclosure that is made, taken or received in the course of appointment, re-appointment or peer review activities. I further release from liability and agree not to sue any and all individuals and organizations who communicate or otherwise provide information to any YNHHS Affiliate and its representatives, employees, agents and members concerning my professional competence, ethics, character, and other qualifications for membership and privileges on the Medical Staffs of the YNHHS Affiliates.

ATTESTATION

I agree that photocopies of this document will be as binding as the original and attest to the fact that the signature below is my own.

Signature and Date

YALE NEW HAVEN HEALTH
MEDICAL STAFF REQUIREMENTS

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. The following documentation is required:

Measles, Mumps, and Rubella (MMR)

- Documentation of 2 doses of measles, mumps, and rubella (MMR) vaccinations
  OR
- Positive titers/blood tests for MMR

Varicella (Chickenpox)

- Documentation of 2 doses of varicella vaccination
  OR
- Positive titer (blood test for varicella)
  OR
- Clinician documented verification of past chickenpox (varicella) or herpes zoster (shingles)

Hepatitis B

- Date of completion of immunization series
  OR
- Signed attached declination and waiver

Tetanus/Diphtheria/Pertussis (Tdap) (Strongly recommended in CT; required in RI, and required for all healthcare workers in Pediatrics, Emergency Departments and all staff who have direct contact with infants under the age of 6 months)

- Documentation of any adult or adolescent dose Tdap vaccine within the past 10 years

Influenza

- Documentation of the seasonal flu vaccine, applicable from September – March 31

COVID-19

- Strongly recommended, but not required

Tuberculosis (TB) Screening

- Documentation of **two** negative TB skin tests (i.e. PPD, TST or Mantoux skin test within the past year)
  OR
- a negative TB blood test (i.e. Quantiferon, T-spot, or BAMT) within the past six months.

  If you have had a previous positive TB skin test OR a positive blood test OR chest x-ray report for a positive PPD OR if you've ever received treatment for active or latent tuberculosis, please provide applicable documentation.

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

Patient facing medical staff may be expected to complete annual N95 respirator fit testing and should have adequate color vision to discern color variations during patient care and test interpretation. These services along with serological testing and vaccinations are available at no charge to Medical Staff members at YNHHS Occupational Medicine and Wellness Services (OMWS) Clinics. Medical Staff members may contact OMWS at the following numbers:

- YNHH YSC: 203-688-2462 (1st floor, YNHH YSC East Pavilion)
- YNHH SRC: 203-789-3392 (175 Sherman Avenue, 5th floor)
- Bridgeport Hospital: 203-384-3613 (226 Mill Hill Ave # 2)
- Greenwich Hospital: 203-863-3483 (Watson Pavilion, 2nd floor)
- L&M Hospital: 860-442-0711, ext. 2289 (L&M Hospital)
- Westerly Hospital: 401-348-3783 (Westerly Hospital)