

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 <u>ENCLOSE COPY</u> ):		
NPI#		
IMMUNIZATIONS: See attached for information and return immunization form with this application.		

**PART II- Current Position:**

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

### PART III- Medical Staff Education Training:

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

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

Indicate completion date:

### PART IV- Rotation Schedule:

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

\_\_\_\_\_  
Signature, Clinical Fellow

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature, Chief/Chair

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name, Chief/Chair

\_\_\_\_\_  
Date

Indicate YNHHS Delivery Network:

BH      GH      LMH      WH      YNHHS

## PRACTICE HISTORY INFORMATION

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

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

### **CONTROLLED SUBSTANCE PRESCRIBING**

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

### **PROFESSIONAL MEMBERSHIPS**

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

### **EDUCATION**

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

### **COMPLIANCE**

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

Name \_\_\_\_\_

Please PRINT

- Medicaid program?
- b. crimes or offenses related to the abuse or neglect of patients in connection with the delivery of health care?  Yes  No
  - c. crimes or offenses involving fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of health care or involving any act or omission in a program financed in whole or in part by any federal, state or local government?  Yes  No
  - d. obstruction of justice?  Yes  No
  - e. crimes or offenses related to the manufacture, distribution, prescription or dispensing of any controlled substance?  Yes  No
  - f. any other felony or misdemeanor crimes or offenses (excluding only motor vehicle speeding violations and parking tickets)?  Yes  No

**HEALTH CARE FACILITY MEMBERSHIP & PRIVILEGES**

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

**HEALTH / BEHAVIORAL**

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

**LIABILITY HISTORY**

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

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

Name \_\_\_\_\_  
Please PRINT

**CONFLICTS OF INTEREST**

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

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

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

**YALE NEW HAVEN HEALTH  
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 month)**

- 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**

- Documentation of completed vaccination series and at least one booster dose. The brand and date(s) of vaccine and booster must be included.

**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 bring 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: 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)

**YALE NEW HAVEN HEALTH  
HEPATITIS B VACCINE DECLINATION**

**(Please sign if you are declining HepB vaccination):**

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

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(Signature)

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Please print Full Name

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(Date)