MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS, INC.
NON-MCWAH HOUSESTAFF ASSIGNMENT FORM

Please PRINT and complete page 1

Listed below is the form that is used to report assignments of Non-MCWAH housestaff to MCWAH institutions. The purpose of the form is to notify the administrator of the receiving hospital of the arrangements for professional liability coverage. This form is also used by the receiving hospital to claim Medicare reimbursement. A MCWAH housestaff time record must be completed and returned to the MCWAH Office at the conclusion of the rotation. The Confidentiality Agreement, Background Information Disclosure (BID) form and Consumer Authorization form must also be completed. Any changes to information provided on the Background Information Disclosure form must be reported to MCWAH or the MCWAH Program Director for your rotation within 24 hours. The resident must also attach a certificate of professional liability insurance, documentation of health requirements and proof of OSHA Bloodborne Pathogen Training compliance. This form should be signed by the resident's Program Director **and** the MCWAH Program Director. This form (and accompanying forms) should be sent to the MCWAH Office at least **3 months prior to the rotation**.

Non-MCWAH residents and fellows must have either a current Wisconsin Resident Educational License (REL) or a full and unrestricted current Wisconsin Medical License. A copy of the license must be provided to MCWAH as part of the rotation approval process. Information about each of these licenses can be obtained by the Wisconsin Department of Safety and Professional Services
.

MCWAH will assign a five-digit number to the resident and report that number back to the Program. The resident must use that number after his/her signature when making chart entries at CHW, FMLH or ZVAMC.

SECTION 1 To Be Completed by the Applicant.

Resident Name ______________________ Social Security # ______________

Current Address ____

Phone Number ______________________ Email ______________

Medical School ______________________ Graduation Date ______________

If IMG, ECFMG # __________ Certificate Date __________ Date of Birth ______________

Dates of MCWAH Rotation __________ to __________ MCWAH Program ______________

NPI # ______________ DEA #:______________

☐ WI REL # ______________ ☐ WI License # (if applicable) ______________

Please list all of your current and previous GME Training in the United States:

Name of Facility ______________ Program ______________ PG Level(s) __________

Dates of Training ______________ to ______________

Name of Facility ______________ Program ______________ PG Level(s) __________

Dates of Training ______________ to ______________

Additional Info/Training ______________________

Signature of Resident/Fellow ______________________ **Date** __________

SECTION 2 To Be Completed by the Applicant's Program Director.

I request approval for the above resident to function in your institution for the period noted. I have reviewed his/her credentials and certify them as acceptable. Our hospital will not claim Medicare reimbursement for this rotation. Our home institution will provide the resident with primary professional liability insurance (PLI) for the resident for this rotation in the amount of $1 million per occurrence and $3 million in aggregate and excess professional liability coverage in the amount of $5 million. In addition, if the professional liability coverage is a claims-made policy, the resident's home institution agrees to provide an extending reporting period or "tail" for the resident at the time the resident terminates or leaves his or her training program.

Submit the following:

☐ Malpractice Insurance – PLI Certificate Attached
☐ MCWAH Confidentiality Privacy Form
☐ HIPAA Training Post Test
☐ Background Information Disclosure w/Consumer Authorization Form
☐ CHW Compliance Training Post Test

Froedtert Network Access (For rotations to Froedtert Health Entities Only)

☐ EPIC Access for Clinical Documentation ☐ EPIC Read Only Access
☐ Other applications access needed (please specify): ______________________

Healthcare Information - Attach Documentation to Verify

☐ TB Testing (within last 90 days)
☐ Measles Antibody Titer or 2 MMR Vaccinations
☐ Rubella Antibody Titer or 1 MMR Vaccination
☐ Hepatitis B Vaccine Series or Positive HBSAB Titer
☐ Mumps Antibody Titer or 2 MMR vaccinations
☐ Positive Antibody Titer or 2 Documented Varicella Vaccinations
☐ Bloodborne Pathogen Training
☐ Flu shot (only if rotation is between November 1 and April 1)

Signature of Resident's Program Director ______________________ **Date** __________

SECTION 3 To Be Completed by MCWAH Program.

Program ______________________ Hospital of Rotation: ❑ FMLH ❑ CHW ❑ VAMC Other______________

MCWAH Program Director's Signature ______________________ Date ______________________

MCWAH ID # Assigned __________

SECTION 4 MCWAH Office Only. **Last Name ____________________**

1. Date Complete Documentation Received ____________
2. Documentation of the Health Care Screening
   Documentation of health care screening is sent to MCW Occupational Health for review, approval and tracking.

Requirements	Received by MCWAH	Approved by Occupational Health	Complete
TB Testing			
Measles Antibody Titer or 2 MMR Vaccinations			
Rubella Antibody Titer or 1 MMR Vaccination			
Chicken Pox or Positive Antibody Titer or 2 Documented Varicella Vaccinations			
Hepatitis B Vaccine Series or Positive HBSAB Titer			
Documentation of OSHA Bloodborne Pathogen Training			

3. **Additional Forms and Requirements**
   The following items are required and verified.

Forms	Date Received	Review Completed
Please √ if this person is a Returnee to: _____Non MCWAH _____RIS		
Confidentiality Agreement		
WI Caregiver Background Information Disclosure (BID) Form w/ Authorization Form. **** If a Non- MCWAH rotator is returning to do another rotation at MCWAH, and MCWAH has conducted a Background Check within the last 4 years it is not necessary to repeat the Background Check. Per BC 6/3/13** **Chris**: Enter date BID form was processed in Non Res file in RIS. Enter date Results from WI check came back in Non Res file in RIS. Fill in States to be queried in Non Res file in RIS and below. **Run National Sex Offender Registry- Run for all WI only at** https://www.nsopw.gov/en. **Per ND 8/5/15. This Registry is run will all Out-of-State requests thru VCI.**		
Chris- Out-of-State to be Queried ____ Data entered on _______ Results Rec'd on _______ by ____ Out-of-State to be Queried ____ Data entered on _______ Results Rec'd on _______ by ____ License: ____ REL: ____		
Certificate of Professional Liability Insurance		
ECFMG Certificate Verified Through CVS Online Service		
HIPAA Training Post Test/ Children's Compliance Post Test		/
Froedtert Required Courses		

4. **Program Letter of Agreement Review**
   All Program Agreements must be reviewed by MCWAH Risk Management prior to being finalized. Approval of the PLA does not constitute approval of the rotation.

   1. Parties to the agreement correctly identified.
   2. Educational objectives and goals are listed.
   3. Site director and faculty who will direct the educational experience identified.
   4. Duration of the rotation specified.
   5. Sponsors and site's policies and procedures will govern conduct.
   6. Sponsor insures their resident/fellow for $1 million per occurrence/$3 million in aggregate.
   7. All required signatures obtained by both sponsoring organization and host. Signature requirements include:
      - **a. Executive Director/DIO**
      - **b. Program Director (MCWAH Program)**
      - **c. Authorized Signatory from Facility**
      - **d. Program Director (Sending Program)**
      - **e. Supervising Physician**

Copy to:
Medical Staff Office ________________ Program Director ________________ MCWAH ID# Assigned ______________________