HARBOR-UCLA MEDICAL CENTER
Affiliating Resident/Fellow Questionnaire

Instructions: **ALL SECTIONS OF THIS FORM MUST BE COMPLETED**. Please complete and submit this form to the Department/Service of the rotation at Harbor-UCLA two weeks prior to the start date along with the HIPAA certificate, Code of Conduct Exam & Acknowledgment, Medical License, DEA, and ECFMG certificate (if applicable). All of these forms are available on the *Visiting Resident – Check in* section of our website at: www.harbor-ucla.org. Housestaff must register with Graduate Medical Education/Medical Administration by visiting room 8E-8 on the first day of each rotation between 8:30 A.M. and 5:00 P.M, Monday - Friday. Questions should be referred to the Graduate Medical Education Office (310) 222-2911. **PLEASE PRINT LEGIBLY.**

Sending Hospital: ______________________________ **Department:** ________________________________

Will be sending resident: _______________________ **MD** ☐ **DO** ☐ **DDS** ☐ **to Harbor-UCLA Medical Center**

Department or Service: ___________________________ **Physician's NPI #:** ___________________________

Affiliation dates will be: ______________________________ **to** ______________________________________
Month/Day/Year Month/Day/Year

** **NOTE**: **If a scheduling change occurs, i.e., change of date or cancellation, an adjusted form must be completed and turned in to the GME Office.** **

Physician's Home Address: ____
Street Address City, State Zip Code

Phone No.: Home ______________________ **Pager** _______________________ **Work** ____________________

Social Security #: ________________________ **Postgraduate Year Level:** ___________ **Fellow? Yes** ☐ **No** ☐
(PGY 1, 2, etc.)

Medical School: _________________________________ **Month/Year Graduated:** _____________________

** **NOTE**: **For International Medical Graduates, an ECFMG Certificate is required to begin rotations at Harbor-UCLA Medical Center. A copy of the ECFMG Certificate must be submitted/presented to the GME Office either prior to or on the first day of service/rotation.** **

International Medical Graduates: **ECFMG Certificate #**: _______________ **Date Issued:** ________ Copy Required

☐ **Check here if not licensed** ☐ **Code of Conduct** Copy Required ☐ **HIPAA Certification** Copy Required

California Medical/Dental License #: ____________________ **Exp. Date:** ___________________ Copy Required

Physician DEA #: _______________________________ **Exp. Date:** ___________________ Copy Required

Person to notify in case of emergency: _________________________ **Phone No.:** __________________

Your Program Director's Name: ______________________________ **Phone No.:** __________________

I have received, read, and understand the attached information regarding Hospital Policies.

Signature: _____________________________________ **Date:** _____________________________

LName, FName

FOR ADMINISTRATIVE USE ONLY

PPG: Y __ N __ N/A __ **LOA**: Y __ N __ N/A __

_______________________ **T** ___________________________ ___________________________
Physician I.D.# Parking/Meals Issued; Initials Pharmacy Req. Date; Initials

REVISED 01/10 njc

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MEDICAL RECORDS

1. **Legibility** – Physicians must sign their name and print their name with Physician I.D. number unless a legible ink stamp of the physician's full name is used.
2. **Correcting errors** – draw one line through the erroneous entry. Write the word "error" above the line followed by your initials, date and time.
3. **Dates and Times**: All orders and entries dated and timed.
4. **Late entries** – Designate the entry or note at "Late entry". Date and time the note as the time when the note is actually written. Do not try and squeeze the entry in between previous entries in the medical record.
5. **Informed Consents** – Must be witnessed and signed appropriately. Be sure to use interpreter/Spanish form when appropriate. Make sure to use *inform consents* for administration of blood products and radiocontrast material.
6. **Timeliness of Documentation** – All reports and notes must be completed in a timely manner: *Histories & Physicals* – 24 hours; *Progress Notes* – daily; *Operative Reports* – immediately post-op; *Discharge summaries* – ASAP after discharge.
7. **Signing Orders** – *Verbal orders* – must be signed immediately; *Phone orders* – within 24 hours.
8. **Pain assessments** (use 1-10 scale); **Reassessments** (for patients previously identified as having pain; use the same pain scale and document an appropriate intervention).
9. **Utilization Management**: Indicate patient's need for continuing hospitalization; avoid terms such as "status quo", "looks good", "home soon". Good example, "The patient requires continued acute hospitalization for evaluation and management of severe hypoxemia".
10. **"Range Orders"** (e.g. 1-2 tabs q 4-6 hrs) are not permitted; **"prn" medication orders** must include both the frequency and indication.
11. **Patient Confidentiality** – avoid patient care discussions in public areas; do not take confidential patient information home with you.
12. **Conscious Sedation/Restraints** – use and fully complete the hospital forms. The forms are located at all clinical workstations.

PATIENT SAFETY

1. **Communication**: Unapproved abbreviations.
2. **Patient Identification** – remember to use a “Time Out” before all invasive procedures or administration of blood products. The “Time Out” must be documented in the medical record.
3. **General Safety**: All Codes, by color.
4. **Fire Safety**: Please review the nearest fire alarms, extinguishers and exits; understand *“RACE”* and *“PASS”*.
5. **Preventing Infections**: Remember to wash your hands before and between patient contacts.
6. **Read backs**: Nurses should read back to physicians any verbal or phone orders given; lab or nursing staff should request the housestaff to repeat the critical results back to them.
7. **Risk Management** – Please promptly report medication and other medical errors by completing and “Event Notification Form”.
8. **Housestaff Supervision** – All procedures to be performed under the supervision of Attendings or supervising residents, unless previously deemed “competent” to perform procedure at hand by Program Director.

OTHER

Autopsies – Autopsies provide valuable training and feedback regarding patient care. Please obtain consent for autopsy when appropriate.

Patient Advocate – Please direct patients with complaints or special needs to Magdalena Valladolid, ext 2151.

REVISED 10/09 njc