Welcome to Children's

WE ARE PLEASED YOU ARE JOINING CHILDREN'S NATIONAL MEDICAL CENTER FOR PART OF YOUR MEDICAL TRAINING!

THIS PACKET INCLUDES A WEALTH OF INFORMATION TO INTRODUCE YOU TO CNMC. SEVERAL FORMS REQUIRE YOUR COMPLETION AND SIGNATURE. WE APPRECIATE YOUR COOPERATION IN RETURNING THE NECESSARY PAPERWORK TO OUR MEDICAL STAFF OFFICE ONE – THREE MONTHS BEFORE YOU ARRIVE, TO MAKE YOUR FIRST DAYS AT CHILDREN'S PRODUCTIVE ONES!

INFORMATION MAY BE RETURNED BY MAIL TO:
MEDICAL STAFF OFFICE – CNMC
ATTN: GLORIA RANSOME
12211 PLUM ORCHARD DRIVE, SUITE 310
SILVER SPRING, MD 20904

OR BY FAX TO: (301) 572-1312

FEEL FREE TO CALL GLORIA RANSOME WITH ANY QUESTIONS: (301) 572-1322
E-MAIL: GRANSOME@CNMC.ORG

ROTATING TRAINEES REQUIREMENTS FORM

- Registration Form
- Evidence of Current Medical License (if received)
- District of Columbia Post Graduate Physician Trainee Certificate (not applicable for NIH and Military Institutions)
- Current Curriculum Vitae
- USMLE Step 1 and 2 Scores. Provide Step 3 score, if examination was completed (Not required if a Medical License or Post Graduate Physician Trainee Certificate is submitted)
- ECFMC certificate (if applicable)
- Evidence of MMR, by shot or titer
- Evidence of PPD (within the last 12 months) and chest x-ray for positive tests
- Annual Physical Exam (within one year of the rotation)
- Medication Quiz 100% accuracy required (Emergency dept only)
- Signed Confidentiality Statement
- Parking Form (Sections 1, 2, 4 and 5)
- Sign The Orientation Brochure Acknowledgement
  (Stating you have received and read the Rotating Trainee Orientation Brochure)

The following web-based courses will require a username and password which will be emailed to you when the registration form is received.

- Blood Borne Pathogens (OSHA)
- Safety Compliance Quiz
- CTI ___Inpatient ___Outpatient

****************************FOR OFFICE USE ONLY*************************

ENTERED INTO CHEX: ____________________________
ENTERED INTO STAR/PPM DATE: __________________
PHYSICIAN NUMBER: _____________________________
ENTERED INTO ECHO: ____________________________
ENTERED INTO E-WORKS: _________________________
SENT TO MEDICAL RECORDS: ______________________
SENT EMAIL: ____________________________________
PROCESS COMPLETED ON: _________________________

MEDICAL STAFF OFFICE
REGISTRATION FORM FOR TRAINEES ON ROTATION

Please complete in ink or type

Rotation in (Department Name): ____

Inclusive Dates (month/day/year)**: from** ______________________ **through** _________________

Frequency of time at Children's during the above mentioned dates

(Please check one and be specific, i.e. ½ day per week, etc.)

______ Daily

______ Day(s) per week

______ Day(s) per month

Previous Rotation at Children's: **Yes** **No** (Circle one) **Year:** ___________

Department Contact Name: ______________________________ **Number**: _________________

Name: ____

First **Middle** **Last**

Date of Birth: _________________**Gender: M F Social Security #:**____________________

Address: ____

Street Apartment #

____(_____)______________

City State Zip Telephone Number

Email address: ____ **Pager #:** ________________

Emergency Contact (name and telephone number)**:** _____________________________________

Your affiliating institution's name and state: ____

Training program to which you belong at that institution: _____________________________

The full name of medical/dental school you attend (please avoid abbreviations)**, city and state:**

____

Title: DDS/ DMD/ DO/ DPM/ MD (circle one) **Date received (month/year)** ________________

Your initial field of residency (ex. Anesthesiology, Pediatric Surgery, Radiology, etc.)**:** __________

____

Number of prior post-graduate training years (as resident or fellow)**:** _______________________

Was one of your post-graduate years of study spent in generalized study or in a transitional program?

(Circle one): **Yes** **No** **Not Applicable**

National Boards taken? (Circle one) **Yes No Licensed?** (Circle one) **Yes No**

If licensed, list state(s): ____

1. **Are you a physician or dental trainee (resident or fellow) in an ACGME- or ADA-accredited training program?** (If yes, proceed to next item; if no, skip to item 6).

2. **Date Graduated**: ________________________ **Degree awarded**: _____________________

3. **Prior residencies or fellowships:**

a. Specialty: _____________________ Dates: ___________________

b. Specialty: _____________________ Dates: ___________________

c. Specialty: _____________________ Dates: ___________________

d. Specialty: _____________________ Dates: ___________________

4. ***USMLE Step 1** Score:_____________________ Date Taken: ________________

***USMLE Step 2** Score: _____________________ Date Taken: ________________

***USMLE Step 3** Score: _____________________ Date Taken: ________________

(Must provide copies of scores from the licensing board)

5. ***ECFMG Number** (if applicable):_____________ Date Valid: ________________

(Must provide copy of certificate)

6. ***Licensing**

State: _________________________ Expiration Date: ____________

State: _________________________ Expiration Date: ____________

DEA Number: ____

(If you do not have one a temporary number will be assigned)

Have you been offered the Hepatitis-B vaccine? (Circle one) **Yes No**

If yes, did you receive it and when? ____

***I attest that the information that I have provided (including rotation dates) is accurate to the best of my knowledge.**

____ ________________________

Signature **Date**

CHILDREN'S NATIONAL MEDICAL CENTER EMPLOYEE CONFIDENTIALITY AGREEMENT

Employee Name ______________________________ Employee ID: _____________
(Last 5 digits of SSN)

Employee Department ____

Children's National Medical Center is committed to maintaining the highest standards of confidentiality. Recognizing that preserving confidential information rests with each employee, the intent of this statement and agreement is to alert employees to their specific responsibilities.

I, the undersigned, acknowledge that I understand and agree to adhere to the following statements:

1. I will abide by the provisions set forth in the CNMC Confidentiality Policy (CH:HR:64), CNMC Information System Security Policy (CH:A:27) and CNMC Appropriate Use of Information Resources Policy (CH:A:32).

2. **All patient information** (oral, written or electronic, past, present and future, medical, financial or demographic) will be held to the highest level of confidentiality. I will not release, discuss, or disclose any patient information that is not allowed under Federal HIPAA Regulations, or is appropriately authorized or is required by law.

3. I understand that in the performance of my duties I may have access to **sensitive information** and/or reports related to other employees, organizational design or systems design, source codes, business and financial planning or status and other information related to organizational performance, planning, and development. I agree that I will not disclose such information.

4. **System Security and Access**:

   a. I consider my CNMC logon ID to be the equivalent of my signature and I am responsible for all entries made under my logon ID.
   b. I will maintain proper password security by not revealing my password to anyone.
   c. I will protect the security of the CNMC Information Systems by not providing anyone else access to the information system.
   d. I will not leave my work station /terminal unprotected while I am logged onto the CNMC Information System
   e. I will report suspected security violations immediately to my Supervisor or the Security Coordinator or Director of my Department
   f. I will access information resources specifically computer systems, only for purposes related to the performance of my assigned job responsibilities.
   g. I understand that CNMC reserves the right to monitor information systems file access at any time. I will cooperate with periodic necessary inspection of data and equipment assigned to me.
   h. I understand that all CNMC systems and applications belong to the organization. As such, CNMC has the right to audit, monitor, and inspect all information on the systems including but not limited to use of e-mail, databases, and documents.

5. I understand that this form will become an official part of my employee file. Failure to comply with the provisions in this document as well as the policies referred to within it, will result in disciplinary actions up to and including termination of employment from Children's National Medical Center.

Employee Signature: ____________________________________ Date: _____________

ORIENTATION BROCHURE ACKNOWLEDGEMENT

I acknowledge receipt of my copy of the Contract/Agency/Non-Agency/Volunteer Orientation Brochure and understand that it is my responsibility to know and abide by its contents.

Print Name: ________________________________

Signature: __________________________________

Date: ______________________________________

Department: ________________________________

WEB BASED TRAINING INSTRUCTION SHEET FOR ROTATING TRAINEES

1. Clinical Transformation Initiative (CTI) is required for most rotating trainees. This training **MUST** be completed prior to the start of your rotation.

   Go to http://www.dcchildrens.com/dcchildrens/fordoctors/wbt.aspx

   The trainee will view the module applicable to them. Trainees who will be entering orders in the system are required to take the **Inpatient Provider** module; all other trainees will be required to that the **View Only for Outpatient Providers** module.

   After choosing the appropriate module, you will be asked for a login and password which is:

   Login: ROTATINGDOC (uppercase letters)
   Password: TRAINME (uppercase letters)

   Trainees will be required to demonstrate their competency after viewing the modules by taking the competency tests described below.

2. All trainees, regardless of which department your rotation will be in, are required to complete the competency tests through our CHEX program. The competency tests can be accessed through http://chexweb.knowledgeplanet.com . The website will require a password. The Medical Staff Office will contact you with an assigned login and password once the registration form is received.

   Depending on your rotation department, some or all of the following tests must be achieved:

   - **CNMC – CTI Competency for Inpatient Provider**
     OR
   - **CNMC – Competency for View Only, Outpatient Providers**
   - **CHEX – Bloodborne Pathogens V4.0**
   - **NEW EMPLOYEE ORIENTATION – SAFETY COMPLIANCE QUIZ**

3. In order to pass the competency tests, trainees will be required to achieve a score of at least 80% on the tests. If the trainee is unable to pass the tests in more than 3 attempts, remedial training will be required.

****If you are experiencing difficulty logging on to the websites, please disable all pop-up blockers.**

MEDICATION POLICIES PHYSICIAN ORIENTATION SHEET

This sheet summarizes key elements of the CNMA Medication Policies, with particular attention to strategies to avoid medication errors through proper physician ordering practices. CNMC has identified 15 items representing best practices for medication prescribing. The first ten listed below are judged to be critical in preventing serious errors. Therefore, the pharmacy will not process orders containing any of these errors and will require the prescribing physician to rewrite the order in correct format.

1. Date is on each individual order

2. Weight is on each order form

3. Medication data is complete and accurate

    a. Drug is properly identified
    b. Route of administration is specified
    c. Dose of medication is specified
    d. Frequency of administration is specified

4. Signature/name or pager number is legible

5. Order is legible

6. Units are written without abbreviations
   Note that when units are abbreviated as “U,” there is the possibility that it would be misinterpreted as a “0,” resulting in a potential 10-fold dosage error (e.g. 10 U being read as 100.

7. No leading decimal points
   This represents another 10-fold dosing error problem, whereby the decimal point could be overlooked: .5 mg being read as 5 mg. The correct order would be written as 0.5 mg.

8. No trailing zeros
   A trailing zero also may cause 10-fold errors: 5.0 mg being read as 50 mg. The correct order would be 5 mg.

9. Digoxin orders have two physician signatures
   This forces two physicians to calculate the proper dosage of this dangerous medication.

10. Narcotic orders specify mg/kg/dose specified
    This acts as a double-check for this dangerous class of medications, to allow nurses and/or pharmacists to check physicians’ dosage calculations.

11. PRN orders have frequency and indication specified

12. No improper/unapproved abbreviations are used

13. Time is on each individual order

14. Renewals indicate what is renewed

15. All orders specify mg/kg/dose
    Although only narcotic orders will be rejected for not having this designation, all pediatric drugs should include this clarification to help spot errors.

When you have read and understand the above information, please complete the quiz.

QUIZ FOR MEDICATION PRESCRIBING

1. Which of the following is/are included in the medication policy?
- **a. Every order must include date, time, patient weight, drug dose/route/frequency.**
- **b. There should be no leading decimal points and no trailing zeros.**
- **c. Digoxin orders must have two physician signatures.**
- **d. All orders must be legible with a legible name or beeper number.**
- **e. All of the above are correct.**

2. Choose the correct order.
- **a. Morphine 0.5 mg q4h prn.**
- **b. Morphine .5 mg IV q4h prn.**
- **c. Morphine 0.5 mg IV q4h prn pain.**
- **d. Morphine 0.5 mg IV q4h prn.**
- **e. Morphine 5.0 mg IV q4h prn pain.**

3. A one-month old boy weighs 4.8 kg. Which of the following orders most correctly specifies an appropriate gentamicin dose?
- **a. Gentamicin 12.5 mg IV q8h.**
- **b. Gentamicin 12.5 mg IV q8h (5 mg/kg/dose).**
- **c. Gentamicin 12.5 mg IV q8h (2.5 mg/kg/dose).**
- **d. Gentamicin 12.5 mg IV q8h (7.5 mg/kg/d).**
- **e. Gentamicin 12.5 mg IV q8h (2.5 mg/kg/d).**

4. When an error is made in writing the correct does of a medication, the physician should
- **a. Carefully print the correct number over the erroneous number.**
- **b. Discard the entire order sheet and start anew.**
- **c. Cross out the error until it is unreadable. Then rewrite the order correctly.**
- **d. Cross out the error with a single line, initial, then rewrite the order correctly.**
- **e. Call the pharmacist to alert him/her to possible misinterpretation of the order.**

5. A four-month old baby weighing 4 kg requires his home digoxin medications during his inpatient stay. His cardiologist states that he is to receive the medication at a dose of 10 micrograms/kg/day, given orally in 2 doses. Which of the following orders is correctly written for this patient (assume two physicians sign the order)?
- **a. Digoxin elixir 0.4 cc PO BID (5 mcg/kg/dose).**
- **b. Digoxin 20 mcg BID.**
- **c. Digoxin 20 micrograms PO Bid.**
- **d. May give digoxin home medication as previously prescribed.**
- **e. Digoxin 20 mcg PO BID (5 mcg/kg/dose).**

CHILDREN'S NATIONAL MEDICAL CENTER

IDENTIFICATION BADGE / BUILDING ACCESS / PARKING ACCESS CARD REQUEST FORM

1 CONTACT INFORMATION:

Today's Date: ___/___/______

Last Name: ______________________________ Title: MD DDS DMD PHD RN Other __________________

First Name: ______________________________

Middle Initial: _________

Address: ____

City: ______________________________________ State:__________ Zip Code: _______________

2 BADGE TYPE:

ID only Building Access only Parking/Building Access

3 CNMC STAFF:

Employee ID Number:______________

Department/Unit Assigned:

____

Ext. ______________

Position Title:

____

AUTHORIZATION FOR MONTHLY PAYROLL DEDUCTION FOR PARKING:

I authorize $44.00 $ 77.00 to be deducted from my paycheck for monthly parking.

Signature:

____

4 NON-CNMC STAFF:

Check one:	Agency/School/Company/Other
❑ Board Member	____________________
❑ Community Based MD	____________________
❑ Contractor	____________________
❑ Resident/Fellow/MD	____________________
❑ Student	____________________
❑ Temporary	____________________
❑ Volunteer	____________________
❑ Other	____________________

Department/Unit Assigned:

____

Extension: ______________

Term of Assignment: FROM ___ /___ /20___ TO ___ / ___ / 20____

There is a monthly parking fee for parking access. A monthly parking fee must be paid each month for parking access to continue.

5 PARKING INFORMATION:

Handicap Tag: YES NO

Vehicle Make and Model: ____________________ Color: ___________________________

License plate: _______________________________ State of Registration: ______________

6 RESTRICTED ACCESS: (Authorized signature must be completed prior to access being given.)

Administration – Denise Gravely Price	(5402)	___________	Bone Marrow – Karen Kaucic	(3217)	____________
Engineering – Press Andam	(2040)	___________	MIS – Kelly Styles	(3792)	____________
Pharmacy – Scott Mark /or	(2689)	___________	Animal Lab – Elizabeth Broussard	(3182)	____________
Karla Evans	(5020)	___________	Library – Deborah Gilbert	(3195	____________
Child Protection – Herman Tolbert	(6717)	___________	Inpat. Psychiatry – Barbara Olson	(2356)	____________
Research – Trish Higdon	(4875)	___________	Operating Room – Diane Marie /or	(3607)	____________
MRI – LaVerne Naughton	(5085)	___________	Andrea Garner	(6006)	____________
Cath Lab – Jeanne Ricks	(4809)	___________			

7 AUTHORIZED BY: (** Signature Required)

_______________________________ _______________________________ EXT. _____

Printed Name Signature

**New hires / Temp. Employees – Human Resources Representatives; **Volunteers – Volunteer Services; ***Students - Instructor; **Residents/Contractors/Consultants/All Others – Department Head; **Community Based Physicia - Medical Staff Office Representative; **Board Member – Government & Community Affairs, Hearing & Speech or Carl Spatz

Status level: _____________ Encoded ID number: ___________

Hanging Permit Tag number: ____________ Parking level assignment: ___________

Date entered into Geoffrey system : ___________ Updated in Geoffrey system: _____________

(Completed by parking office staff)