KAISER PERMANENTE®

VISITING RESIDENT/MEDICAL STUDENT REGISTRATION

DEMOGRAPHIC INFORMATION

Legal First Name:	**Middle Name**:	**Legal Last Name:**	**Maiden/Other Name:**

Gender: ☐ **Male** ☐ **Female**	**SSN:**	**Date of Birth:**	**Current PG Year:**	**Title (MD, DO, DPM):**

Home Address:	**City, State, Zip:**	**Country of Birth:**

Email address:	**Cell Phone:**	**Pager:**

☐ **Resident**	☐ **Fellow**	☐ **Medical Student**	☐ **Other** *(please specify)*

Current Program:	**Current Institution:**	**Program Start Date:**	**Anticipated Graduation Date:**

Rotation: *Please enter each rotation on a different line*	**Start Date:**	**End Date:**
1.		
2.		
3.		

CA Medical License:	**Expires:**	**DEA License:**	**Expires:**

ECFMG License:	**Issued:**	**National Provider Identifier:**

PREVIOUS KAISER PERMANENTE EXPERIENCE

Have you ever participated at a Kaiser Permanente facility as a medical student, volunteer, resident, fellow, per diem physician, or staff?

☐ **No** ☐ **Yes** **If Yes, please completes the following information:**

ROLE/TITLE: _____ **NUID** (if applicable)**:** _____

DEPARTMENT: _____ **KP FACILITY:** _____

START DATE: **END DATE:**

MEDICAL SCHOOL INFORMATION

Medical School Name:

City/State/Country:	**Graduation Date:**	**Degree**:

POSTGRADUATE TRAINING

List **all years** of postgraduate training, employment, and time off since receiving a medical degree.
Please account for every academic year since medical school graduation, with no gaps.

FROM (mm/dd/yyyy)	**TO** (mm/dd/yyyy)	**SPECIALITY (PGY) / OTHER ACTIVITY**	**INSTITUTION/LOCATION**

_____ _____

Signature ***Date***

KAISER PERMANENTE®

2860

CHILD ABUSE REPORTING REQUIREMENTS

Please complete and sign form, then return to Kaiser Permanente Coordinator or upload to MedHub.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)
* First Name	Middle Name	* Last Name	

1. REQUIREMENTS

Section 11166 of the Penal Code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment who he or she knows or reasonably suspects has been the victim of child abuse or who he or she knows or reasonably suspects that a child is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

The identity of all persons who report shall be confidential and disclosed among agencies receiving or investigating mandated reports, to the district attorney in a criminal prosecution, or in an action initiated under Section 602 of the Welfare and Institutions Code arising from alleged child abuse, or to counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code, or to the county counsel or district attorney in a proceeding under Part 4 (commencing with Section 7800) of Division 12 of the Family Code or Section 300 of the Welfare and Institutions Code, or to a licensing agency when abuse or neglect in out-of-home care is reasonably suspected, or when those persons waive confidentiality, or by court order.

“Health practitioner” includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code; marriage, family and child counselors, emergency medical technicians I or II, paramedics, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; psychological assistants registered pursuant to Section 2913 of the Business and Professions Code, marriage, family and child counselor trainees as defined in subdivision (c) of Section 4980.44 of the Business and Professions Code; state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; and religious practitioners who diagnose, examine, or treat children.

Volunteers whose duties include direct contact with and supervision of children are not mandated reporters, but are encouraged to report instances of child abuse and neglect.

Your department chief or supervisor should be notified whenever you believe you may be required to report suspected child abuse.

I understand and agree, if in a “Child Care Custodian” or “Health Practitioner” classification, as defined above, to comply fully with the above-cited provisions of the California Penal Code, in accord with procedures established by my Employer/Medical Center.

2. EMPLOYEE SIGNATURE

Signature

* Employee Signature	* Date (mm/dd/yyyy)

Facility / Department

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit buttion.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

KAISER PERMANENTE®

2950 ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

Please complete and sign form, then return to Kaiser Permanente Coordinator or upload to MedHub.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)

* First Name	Middle Name	* Last Name

1. ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

California Welfare and Institutions (W&I) Code Section 15659 requires Kaiser Permanente Medical Program to provide all "health professionals" and "care custodians" information concerning their responsibility to report incidents of observed, known, or suspected elder and dependent abuse. All health practitioners or care custodians must sign a statement acknowledging receipt and understand of the **mandatory** elder and dependent abuse reporting requirements. Kaiser Permanente must retain the signed statement.

Elders are persons 65 years of age or older. **Dependent adults** are persons between the ages of 18 and 64 with physical or mental limitations such as physical or developmental disabilities or age-diminished physical or mental abilities. The law also expressly includes any person between the ages of 18 and 64 who is admitted as an inpatient to an acute care hospital or other 24-hour facility as a dependent adult. (W&I Code Sections 15610.23, 15610.27 and 15701.2)

Abuse of and elder or dependent adult means either of the following:
(a) Physical abuse, including lewd or lascivious acts, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering; or
(b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. (W&I Code Section 15610.07)

At Kaiser Permanente, a physician, nurse, and licensed or unlicensed health care professional, including administrative and support staff, who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of elder and/or dependent abuse, or reasonably suspects elder and/or dependent abuse, **shall report by telephone immediately or as soon as practically possible and by written report within two (2) working days** as follows:
(a) to the long-term care ombudsmen or the local law enforcement agency when the abuse is alleged to have occurred in a long-term care facility;
(b) to the State Department of Mental Health, the State Department of Developmental Services, or the local law enforcement agency if the abuse is alleged to have occurred in a state mental health hospital or state developmental center; or,
(c) to the adult protective services agency or the local law enforcement agency when the abuse is alleged to have occurred anywhere else. (W&I Code Section 15630)
All incidents should be documented and forwarded to the appropriate agency in accordance with local medical center procedures.

I certify that I have read and understand this statement and will comply with the requirements of the Elder and Dependent Abuse Reporting Law.

2. SIGNATURE

* Employee Signature	* Date (mm-dd-yyyy)

Facility / Department

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit buttion.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

KAISER PERMANENTE®

2870

CONFIDENTIALITY AGREEMENT

* Employee ID	* Work Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* Employee First Name	Employee Middle Name	* Employee Last Name
* Job Title	* Location	

AGREEMENT

In my job, I may see or hear confidential information in any form (oral, written, or electronic) regarding:

- HEALTH PLAN MEMBERS AND PATIENTS AND/OR THEIR FAMILY MEMBERS (such as patient records, test results, conversations, financial information)
- EMPLOYEES, PHYSICIANS, VOLUNTEERS, CONTRACTORS (such as employment records, corrective actions/disciplinary actions)
- BUSINESS INFORMATION (such as member rates, marketing plans, financial projections)

I will protect the confidentiality of this information. Access to this information is allowed only if I need to know it to do my job.

I AGREE THAT:

1. I will protect the privacy of our patients, members, and employees.
2. I will not misuse confidential information of patients, members, employees or Kaiser Permanente (including confidential business and personnel information) and I will only access information I have been instructed or authorized to access to do my job. With respect to Protected Health Information, I will only access or use such information as it is necessary to provide medical care to the member and/or patient or as necessary for billing and payment or health plan operations.
3. I will not access my family members' PHI. I will not access my own medical records unless my job duties authorize me to have access to electronic medical records (for example, KP HealthConnect). Instead, I will follow the same procedures that apply to non-employee health plan members.
4. I will not share, change, remove or destroy any confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure or the instructions of my supervisor/chief of service (such as shredding confidential paper). If a demand is made upon me from outside Kaiser Permanente to disclose confidential information, I will obtain approval from my supervisor before disclosing such information.
5. I understand that inappropriate or unauthorized access, use or disclosure of PHI may result in legally required reporting to governmental authorities, including my name.
6. I know that confidential information I learn on the job does not belong to me and that Kaiser Permanente may take away my access to confidential information at any time.
7. If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am responsible if I fail to protect my password or other means of accessing confidential information.
8. I will not use anyone elses password to access any Kaiser Permanente system unless I am authorized to do so. If I am authorized to do so (e.g., in order to perform computer systems maintenance), I will follow procedures to ensure the password is changed and that confidential information is not at risk.
9. I will lock my computer when I step away to prevent someone else accessing the computer under my logon. I understand that I am personally responsible for any accesses under my logon.
10. If I leave Kaiser Permanente I will not share any confidential information that I learned or had access to during my employment.
11. On termination of my employment, I will promptly return to Kaiser Permanente all originals and copies of documents containing Kaiser Permanente's information or data in my possession or control, unless the documents were provided to me as part of my employment record.

Next Page >

* First Name	Middle Name	* Last Name
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

AGREEMENT - (Continued)

Examples of Breaches of Confidentiality (What you should NOT do.)

These are examples only and do not include all possible breaches of confidentiality.

- Unauthorized reading of patient account information.
- Unauthorized reading of a patient's chart.
- Unauthorized access to my own medical information if my job duties do not authorize me to have access to electronic medical records (for example, KP HealthConnect).
- Accessing medical information of friends, co-workers, family members, or anyone else, unless it is required for my job.
- Discussing confidential information in a public area such as a waiting room or elevator.
- Discussing or otherwise sharing confidential information with anyone in your personal life, including family members or friends.
- Accessing records for any reason other than for legitimate business purpose.
- Accessing records of family, friends, co-workers, patients in the media, well known political figures, celebrities, or anyone else about whom you are curious.
- Sending confidential information to your personal e-mail account, unless you are authorized to do so and the information is transmitted in accordance with required procedures (e.g., encrypted).
- Saving confidential electronic information to a KP-owned or non-KP-owned flash drive, CD, or any other removable or transportable storage device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Saving confidential electronic information to a KP-owned or non-KP-owned workstation, laptop computer, personal digital assistant, or any other mobile computing device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Using personal devices (digital cameras, camera phones) to take photographs that may include confidential information as the primary subject or in the background.
- Documenting or referencing confidential information on any social networking site, such as Twitter, My Space.
- Telling a co-worker your password so that he or she can login to your work.
- Telling an unauthorized person the access codes for employee files or patient accounts.
- Being away from your workstation while you are logged into an application, without locking your system to protect confidential information.
- Unauthorized use of a co-worker's password to logon to a Kaiser Permanente information system.
- Unauthorized use of a user ID to access employee files or patient accounts.
- Allowing a co-worker to use your secured application* for which he/she does not have access after you have logged in.

* secured application = any computer program that allows access to confidential information. A secured application usually requires a user name and password to log in.

CONFIDENTIALITY AGREEMENT

* First Name	Middle Name	* Last Name
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

AGREEMENT - (Continued)

12. I understand that I am responsible for my access, use, or misuse of confidential information and know that my access to confidential information may be audited.
13. I understand that my supervisor/chief of service or other managers and/or the Compliance Hot Line are available if I think someone is misusing confidential information or is misusing my password. I further understand that Kaiser Permanente will not tolerate any retaliation because I make such a report.
14. I understand that patient privacy and security is included in various training programs within Kaiser Permanente (for example: New Employee training, Annual Compliance Training), and by taking such training, I understand the obligations of confidentiality. I further understand that it is my responsibility to secure guidance from my supervisor or manager in the event any questions exist relating to my obligations regarding confidentiality.
15. I understand that this policy is not meant to prohibit any protected rights provided for in the National Labor Relations Act (for represented employees).
16. I understand that failure to comply with this agreement may result in disciplinary action up to and including termination of employment or other relationship with Kaiser Permanente. I understand that I may also be subject to other remedies allowed by law.
17. I understand that I must also comply with any laws, regulations, and other Kaiser Permanente policies, including the Principles of Responsibility that address confidentiality.
18. By signing (or selecting the submit button below), I agree that I have read, understand, and that I will comply with this Confidentiality Agreement.

SIGNATURE

* Employee Signature	* Date (mm/dd/yyyy)

KAISER PERMANENTE®

EMTALA ATTESTATION

I read and understand the EMTALA requirements. I know my role in ensuring adherence to the requirements including escalation of concerns to my department's leadership as needed.

Signature	*Printed Name*	*Date*

Kaiser Permanente Medical Center	*Rotation Program*
Home Institution	*Home Program*

GUIDELINES FOR STANDARD/UNIVERSAL PRECAUTIONS AND PROTECTION AGAINST EXPOSURE TO BLOODBORNE PATHOGENS IN HEALTHCARE SETTINGS

These guidelines apply to ALL employees and physicians in the hospitals, medical office buildings, regional laboratories and other regional services of the Kaiser Permanent Medical Care Program. Additional details are available in your facility's Bloodborne Pathogen Exposure Control Plan. Ask your manager where it is located.

The Kaiser Permanente Medical Care Program mandates the use of Standard/Universal blood and body fluid/substance precautions for all patients and employees as recommended by California and Federal OSHA, the American Hospital Association and the Centers for Disease Control and Prevention (CDC). These guidelines are mandated to protect patients, employees and physicians from the occupational transmission of bloodborne infections, such as Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV). Standard/Universal precautions must be strictly followed whenever there is the possibility of contact with blood or other potentially infectious material (OPIM) from any patient regardless of diagnosis. Failure to comply with Standard/Universal precaution practices will result in disciplinary action. OPIM are defined as: semen, vaginal secretions, cerebrospinal fluid, peritoneal fluid, amniotic fluid, synovial fluid, pleural fluid, pericardial fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood and all body fluids in situations where it is difficult or impossible to differentiate between blood and body fluids.

STANDARD/UNIVERSAL PRECAUTIONS

1. Blood and/or OPIM must be handled in a manner that minimizes splashing, spraying, splattering, and generation of droplets. The use of personal protective equipment (PPE) i.e. gloves, gown, eye shields, masks etc., is required to reduce the risk of occupational exposure. In addition to the use of PPE hand hygiene is required at the start of the work shift, and between dirty and clean procedures on the same patient. Hand hygiene is also required after: contact with equipment or environment that may be contaminated, using the restroom, eating, drinking, smoking, and applying cosmetics. It is required as well before and after: contact with patients and specimens, wearing gloves or other PPE, contact with mucous membranes, and preparing food. Hand hygiene may be accomplished with either waterless degermer or soap and water washing.

2. Gloves are required when anticipated hand exposure to blood and/or OPIM is anticipated. Examples include: venous access procedures (e.g. phlebotomy, IV starts), specimen collection, open wound contact and when handling or touching contaminated items or surfaces.

3. PPE such as gowns and disposable plastic aprons are required during procedures when splashing with blood and/or OPIM is anticipated. Scrubs are NOT PPE.

4. PPE such as masks, face shields, ventilation devices and protective eye wear are required during procedures when splashing, spraying, splatter or droplets of blood and OPIM to the eyes, nose or mouth is anticipated. Eyeglasses are NOT PPE.

5. N-95 NIOSH approved TB respirator masks are required for protection against tuberculosis. Fit testing must be done prior to use of the N-95 mask. Regular masks are required for protection against other airborne transmitted diseases such as chickenpox.

6. Used syringes and disposable sharps must be disposed of immediately at point of use in puncture resistant containers. Do not overfill the containers. Needles should not be recapped or manipulated in any way. If needles must be recapped, a one-hand scooping technique or recapping device must be used. Kaiser has standard sharps safety devices available, which must be used. The safety feature on sharps safety devices must be activated. Education regarding sharps safety devices is required before use.

7. Laboratory specimens must be processed and handled in a safe manner with gloves and placed into leak proof containers labeled with biohazard symbol when required.

8. Emergency resuscitation equipment such as ambubags, mouthpieces, pocket masks, and ventilation devices are required in resuscitation situations.

9. Hepatitis B vaccination is strongly recommended for all employees who have the potential for occupational exposure to blood and OPIM. This is administered in a series of three injections. It is highly effective and safe, and is offered free of charge to all employees.

EMPLOYEE HEALTH

Exposure to blood and/or OPIM via needlesticks, other sharps injury, mucous membranes or non-intact skin requires:

- immediate and thorough washing of the affected area,
- contacting your Manager/designee,
- seeking immediate medical evaluation, and
- contacting Employee Health for documentation of the exposure incident on the Sharps Log.

Signature: _____ Date: _____

Printed name: _____

96373 (Revised 6-92, 01-03)

KAISER PERMANENTE®
Medical Care Program
Southern California Region

HEALTH STATUS INFORMATION

Print Name:	**Date of Birth:**
Name of Institution/Agency:	

Assignment/Rotation Details:

KP Location: _____ **Department:** _____

Assignment/Rotation Dates: _____to_____

Select from one of the options below:

☐ Resident ☐ PA Student ☐ Medical Student ☐ Nursing Student ☐ Pharmacy Student

☐ Observer in Training ☐ Registry/Locum ☐ Traveler ☐ Sub-Contractor ☐ Vendor/Supplier

According to the policy and procedures of Southern California Regional Human Resources (including HR 5.02), 22 CCR Section 7023, and CDC guidelines, all contracted medical center workers (e.g., registry and students) are required to demonstrate current immunity to the communicable diseases set forth in section 1 and 2, and comply with TB screening set forth in section 3.

1. Measles, Mumps, Rubella, Varicella immunization information:

Serologic immunity and/or up-to-date immunization is required. Enter date of titers and check box if immune or non-immune. If titer is negative or non-immune, MUST list most recent immunization date(s). The following number of doses are needed: 2 doses for rubeola, mumps, and varicella; 1 dose of rubella. The first dose of measles, mumps, rubella (MMR) and/or varicella vaccine may be acceptable for clearance if the vaccine series was recently initiated (within last 30 days). The 2nd dose is mandatory per CDC schedule (28 days after 1st dose).

(Diagnosis of a history of chickenpox or shingles by a healthcare provider is acceptable for proof of varicella immunity.)

	Date of Titer	Immune	Non-Immune	Immunization Date(s)		
Rubeola				Dose #1:	Dose #2:	
Mumps				Dose #1:	Dose #2:	
Rubella				Dose #1:		
Varicella				Dose #1:	Dose #2:	History of disease (**choose one**): ☐Varicella or ☐Shingles Date diagnosed:

2.A. Hepatitis B immunization information:

Record of complete vaccine series AND post vaccination positive lab result/titer OR signed declination in section 2B. Individual dose(s) may be acceptable for clearance if vaccination is recent as part of completing a full series. Complete series = 2 doses or 3 doses depending upon formulation.

	Date of Titer	Immune	Non-Immune	Immunization Date(s)			**Formulation** (if known):
Hepatitis B				Dose #1:	Dose #2:	Dose #3:	☐ Engerix/Recombivax ☐ Heplisav-B

2.B. Hepatis B Vaccine Declination:

I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection. I understand by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I have an occupational exposure to blood or other potentially infectious materials, and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series through my agency/institution.

Sign if declining the Hepatitis B vaccine. **Signature:** _____**Date of Declination:** _____

KAISER PERMANENTE®
Medical Care Program
Southern California Region

HEALTH STATUS INFORMATION

3.A. Tuberculosis Symptom Screening - Please answer the following questions:

Do you currently have any of the following symptoms lasting more than 3 weeks, unrelated to confirmed COVID-19 or Influenza infection?

Persistent cough?	☐ YES ☐ NO	Coughing up blood?	☐ YES ☐ NO
Unexplained excessive weight loss or loss of appetite?	☐ YES ☐ NO	Unexplained excessive fatigue or weakness?	☐ YES ☐ NO
Unexplained excessive night sweat?	☐ YES ☐ NO	Persistent fever?	☐ YES ☐ NO

3.B. Tuberculosis Screening Information:

Provide date(s) and result of 2 most recent TB skin tests (TST) or 1 IGRA (QFT or T-Spot). The last TST or IGRA needs to be within the last 12 months and "previous TST" needs to be within 2 years before starting work/rotation. A 2-step TST within a year is acceptable.

Most recent TST Date (within 12 months):	Result (mm of induration*)
Previous TST Date (within 2 years):	Result (mm of induration*)

Last IGRA Date (within 12 months):	Result:

IGRA result- indicate if positive or negative

*Result should be in mm of induration for TST (i.e. "0" if no induration). If your TST/IGRA is newly positive, you will need to provide a report of a negative chest x-ray done after the TST/IGRA. If the TST/IGRA was previously positive, the results of a negative chest x-ray should be within 1 year of start date and on file at your institution/agency.

(If applicable) CXR Date:	Result:

4.Tdap Vaccine: List date of recent vaccine within past 10 years.

Date of Immunization: _____ ***OR*** **Sign if Declining:** _____ **Date of Declination:** _____

5. Seasonal Flu Vaccination: Seasonal flu vaccination available August of current year through April of the following year.

Date of Immunization: _____ ***OR*** **Sign if Declining:** _____ **Date of Declination:** _____

** Masking mandate will be enforced (where applicable) during respiratory virus season (November through April) if current seasonal flu immunization is ***NOT*** yet received ***OR*** if vaccine is declined.

6. COVID-19 Vaccination: Most current formulation of COVID-19 vaccine available as of September of current calendar year.

Date of Immunization: _____ ***OR*** **Sign if Declining:** _____ **Date of Declination:** _____

** Masking mandate will be enforced (where applicable) during respiratory virus season (November through April) if current COVID-19 immunization is ***NOT*** yet received ***OR*** if vaccine is declined.

Attestation: I hereby affirm that the information provided in this questionnaire is accurate and fairly represents my current health status. I understand that any misrepresentation, misstatement or omission in this questionnaire, whether intentional or not, shall constitutes a breach of contract between contractor, or contract agency, and Kaiser Permanente. Any such misrepresentation, misstatement or omission, whether intentional or otherwise, may result in immediate suspension or termination of employment or contracted work by Kaiser Permanente. I understand my employer/agency will receive a copy of this completed form.

Signature: _____ **Date:** _____

Print Name: _____

Address: _____ **Zip**: _____

Phone: _____ **Email**: _____

KAISER PERMANENTE®

2862 DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

Please complete and sign form, then return to Kaiser Permanente Coordinator or upload to MedHub.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* First Name	Middle Name	* Last Name

1. EMPLOYEE INFORMATION

* Work Phone Number - Tieline (###) ###-####	* Work Phone Number - Outside (###) ###-####	NUID # (if known)
Location/Facility Name	Department	

2. ACKNOWLEDGEMENT

I understand that, as a provider of health care, Kaiser Permanente recognizes that alcohol and drug abuse/chemical dependency is a chronic disease and major health problem that can have tragic consequences for individuals, families, and the workplace.

As a condition of employment, all employees are expected to abide by the organization's policy which prohibits the use and/or abuse of drugs and alcohol in the workplace.

By my signature below, I acknowledge, understand, accept, and agree to comply with this policy. I also understand that failure to comply with this policy will result in corrective/disciplinary action, up to and including termination of employment.

DRUG-FREE WORKPLACE ATTESTATION

- I have received a copy of the policy NATL.HR.030, Drug-Free Workplace.
- I have read, understood, and familiarized myself with this policy, and understand that Kaiser Permanente is committed to providing a drug-free workplace.
- I understand that it is my responsibility to comply with this policy, and that this policy applies to me.
- I agree to abide by the terms of the policy, as a condition of employment.
- I understand that violations of this policy will subject me to corrective/disciplinary action, up to and including termination of employment.
- If I have any questions about this policy, I will seek clarification from my manager or a KP HR Representative.
- I understand that, in acknowledgment that chemical dependency is a chronic disease and that rehabilitative treatment is available, KP supports and strongly encourages employees with such problems to seek treatment, and will provide it when conditions and circumstances warrant.
- I understand that the responsibility for seeking, obtaining, and cooperating in such treatment is mine.
- I understand that, if I am experiencing alcohol or drug dependency, I am urged by the organization to make use of KP's confidential Employee Assistance Program, and/or such disability plans, rehabilitation programs, and health coverage plans that may be appropriate.

3. EMPLOYEE SIGNATURE (Required if not submitted online)

* Employee Signature	* Date (mm-dd-yyyy)

KAISER PERMANENTE

Kaiser Permanente Employee Health Services Documents

The Kaiser Permanente Employee Health Services Department (EHS) requires that all visiting medical students, residents, and fellows complete and return the attached documents.

All forms and documents must be sent to the medical center coordinator no later then their specified date. Failure to do so may result in the delay of your rotation start date.

Documents required by Employee Health

- **Heath Status Information Attestation**
- **Copy of up-to-date immunizations records:**
- **Kaiser Permanente Influenza Vaccination Policy** *(review only)*
- **Tdap Vaccine Information Sheet** *(review only)*
- **Health Screening Requirements** *(review only)*
- **Policy and Procedure for Hand Hygiene** *(review only)*
- **Hand Hygiene and Artificial Nail Policy Attestation**

Alternate 1	Alternate 2	Done
TB SCREENING		
• Documentation of 2 negative TB skin tests. (a) If no history of TB skin testing within 2 years, then 2 TB skin tests are needed as: i. A negative 2 step TB test before start of KP assignment; OR ii. A negative TB blood test before start of KP Assignment. (b) If a history of prior TB Skin Testing, then 2 TB skin tests are needed within 2 years (24 months) of the start date of the KP assignment, as: i. A negative TB Skin Test within 1 year; and ii. A second negative TB skin test within 2 years. • TB testing is needed every 12 months to maintain clearance. • Documentation of history and exam negative for TB symptoms or findings within last 30 days. • If documentation of a positive skin test or INH therapy in the past, then need a negative chest x-ray within the past 12 months of starting KP assignment. If engaged on additional or continuing assignment, no update to chest x-ray needed after initial presentation of negative chest x-ray.	Negative TB blood test within 12 months of starting KP assignment.	• 2 negative skin tests OR • Negative blood test OR • If positive tests, then negative chest x-ray plus negative history and physical. Need official chest x-ray report.

KAISER PERMANENTE®

Kaiser Permanente Employee Health Services Documents

HEPATITIS B		
Document Vaccinations (X3) 1st, 2nd, 3rd vaccination 1st and 2nd, > 1 month apart 2nd and 3rd, > 5 months apart PLUS Hepatitis B surface antibody blood test positive titer ***Note***: Everyone must do Hepatitis B surface antibody blood test if no historical proof of Hep B surface antibody.	Declination letter PLUS Hepatitis B surface antibody blood test titer (result may be + or – for Hep B surface AB, but counseling based on results)	• Vaccinations plus • + Hep B s AB test OR • Declination letter • – Hep B s AB test
MEASLES (RUBEOLA)		
Vaccinations, "MMR", (X2) one month or more apart ***Note***: must start vaccination series before cleared to work.	Positive blood titer showing immunity. Declination not allowed	• Vaccinations OR • Positive blood titer
MUMPS		
Vaccinations, "MMR", (X2) one month or more apart ***Note***: must start vaccination series before cleared to work.	Positive blood titer showing immunity. Declination not allowed	• Vaccinations OR • Positive blood titer
RUBELLA		
Vaccination (X1) "MMR"	Positive blood titer showing immunity. Declination not allowed	• Vaccination OR • Positive blood titer
VARICELLA		
Vaccinations (X2) one month or more apart ***Note***: must start vaccination series before cleared to work.	Positive blood titer showing immunity. Declination not allowed	• Vaccinations OR • Positive blood titer
HEPATITIS A (if applicable to job)		
If the individual's main duties involve preparing or serving food or facility/stationary engineers that work (or can be exposed to) brown water. Document Vaccinations (2 vaccinations, 6 months apart) OR Blood test results demonstrating immunity to hepatitis A (Vaccination will be recommended for any individual who lacks immunity.)	Declination to Hepatitis A vaccination	• Received first vaccination for Hepatitis A. Maintain clearance by returning within 7 months for second vaccination. OR • Blood test demonstrating immunity to Hepatitis A OR • Declination documented

Thank you and welcome to Kaiser Permanente Medical Center!

HAND HYGIENE AND ARTIFICIAL NAIL POLICY ATTESTATION

I have been informed of the Kaiser Permanente Hand Health & Hygiene Policy and the requirement to eliminate artificial nails for all persons who provide direct patient care.

Signature	*Printed Name*	*Date*

Kaiser Permanente Medical Center	*Rotation Program*
Home Institution	*Home Program*

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COMMITMENT TO A HARASSMENT-FREE WORK ENVIRONMENT POLICY & ACKNOWLEDGMENT

I acknowledge that I have read Policy NATL.HR.005, *Commitment to a Harassment-Free Work Environment*, and that I am aware of the stated provisions, including the definition of harassment, prohibited conduct, reporting obligations, investigation and remedial action, and no retaliation.

Signature	*Printed Name*	*Date*

Kaiser Permanente Medical Center	*Rotation Program*
Home Institution	*Home Program*

Updated 03/2014

Letter of Reference Release Form
Graduate Medical Education

KAISER PERMANENTE®

Student/Resident/Fellow Name: _____

I hereby request and grant permission to the physicians at Kaiser Permanente Medical Center to write letters of reference on my behalf. I also grant permission to discuss via telephone, in person, or e-mail my candidacy with representatives of the agencies with whom I am seeking such positions. I waive any right to review, receive a copy, or be informed of the contents of any assessment provided under this release.

I also acknowledge that the following factors are among those that will be taken into consideration when writing a reference on my behalf:

- Capacity in which s/he knows me
- Length of time s/he knows me
- Assessment of my professional abilities including strengths and opportunities for improvement.
- My performance according to the ACGME core competencies
    - Patient Care
    - Medical Knowledge
    - Interpersonal and Communication Skills
    - Professionalism
    - Practice-Based Learning and Improvement
    - Systems-Based Practice
- General and specific impressions of my qualifications for the position for which I am applying
- My contributions to the program
- My contributions to the community

I release the writer from any claim.

_____ _____

Signature Date

Please return a signed copy of this form with your rotation documents.

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INTERPRETIVE SERVICES ATTESTATION

I have been informed of Interpretive Services available and have received information on resources for when a patient/member needs language assistance.

Signature	*Printed Name*	*Date*

Kaiser Permanente Medical Center	*Rotation Program*
Home Institution	*Home Program*

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AGREEMENT TO RETURN KAISER PERMANENTE PROPERTY

Instructions:
1. HR Administration, HR Consultant or Manager is responsible for completing form.
2. The form is completed in the following events: Termination, Transfer, New Hire.
3. Manager provides a copy of signed/acknowledged form to employee.
4. Manager place original signed/acknowleged copy of form in employee's department file.
5. Manager fax copy of signed/acknowledged form to the number below.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* First Name	Middle Name	* Last Name

1. ADDITIONAL EMPLOYEE INFORMATION

Department (Description)	Physical Location (Description)

I hereby agree to return the listed items (which have been issued to me) to my manager (or to those departments specifically indicated to the right of the issued item) prior to: a) transferring (unless my manager authorizes property transfer to new department) or b) terminating from the department, or c) upon request by an authorized KP management representative.

My initials appear below, opposite those items that have been issued to me:

2. PROPERTY

Property Type	Initial/Issued By Received Date	Property Transfer Date/New Dept/Auth Mgr Initial	Property Return Date Manager's Initial
☐ Cash (Petty Cash, Change Funds, etc.)			
☐ ID Badge, Security Access Card, Property Pass			
☐ Keys (Types)			
☐ Parking Card			
☐ Verifier Stamp			
☐ Lab Coats, Scrub Suits, Uniforms - Quantity			
☐ Tools: (Attach Description and Serial #)			
☐ Laptop, Printer, Scanner, NRAS Token (Serial #)			
☐ Other computer equipment or peripherals (Attach description or inventory of equipment and Serial #)			
☐ Cellular Phone, Pager, Walkie Talkie (include Serial #)			
☐ Credit Card(s) (AMEX, One Card, Phone Card, Other)			
☐ Palm Pilot, PDA (Include Serial #)			
☐ Assigned Manuals (Type)			
☐ Other company assets: (List on separate sheet(s) as needed.)			
☐ Prescription Pad			

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AGREEMENT TO RETURN KAISER PERMANENTE PROPERTY

* First Name	Middle Name	* Last Name
* Employee ID pending	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)

3. SYSTEMS ACCESS

System Type	Access Start Date	Access Transfer Date	Access Deactivation Date
☐ Computer System Access (Type)			
☐ Cellular Phone, Pager, Walkie Talkie (include Serial #)			
☐ Palm Pilot, PDA (include Serial #)			
☐ Phone/Voice Mail Access			
☐ Security Access Change Funds, etc.			
☐ Pharmacy/Clinical Systems Access			
☐ Funds Disbursement Authority (FDA)			

4. SIGNATURE/ACKNOWLEDGEMENT

* Employee Signature	* Date (mm/dd/yyyy)
* Manager's Acknowledgement of Returned Property (Print)	* Date (mm/dd/yyyy)
* Manager's Acknowledgement of Transferred Property (Print)	* Date (mm/dd/yyyy)

5. PREPARED BY

* First Name		Middle Name	* Last Name
* Employee ID	* Title		* Work Phone Number (###) ###-####