



Franklin Square  
Hospital Center

Centered on You  
*MedStar Health*

March 2010

Dear Doctor:

On behalf of the physicians and staff of Franklin Square Hospital Center, I would like to welcome you to MedStar Health and congratulate you on your acceptance for the 2010-2011 academic year. We will make every effort to ensure a professional, safe and pleasant working environment and hope your experience at Franklin Square Hospital Center is both personally and professionally rewarding.

As part of our new employee hiring process you are required to attend orientation that will begin on **Friday, June 18, 2010**. All new interns are expected to report for duty on **June 18th**. Your program coordinator will e-mail details to you at a later date regarding department orientation.

A pre-requisite to entering residency at Franklin Square Hospital Center is completion of the SiTel on-line orientation training modules and completion of the AHA courses offered at the MedStar Simulation Center. Details pertaining to the on-line orientation training module will be e-mailed to you at a later date. Instructions on how to register for the AHA Courses through SiTel may be found on our web site at [www.franklinsquare.org](http://www.franklinsquare.org). Click on "Residency Programs" and scroll down to "New Intern Packet/House Staff Orientation."

The attached documents contain the forms that you will need to begin employment as a resident physician. Please **print** all documents and read the instructions carefully. Complete all forms and return **them to Rhonna Murgatroyd, Office of Graduate Medical Education, Franklin Square Hospital, 9000 Franklin Square Drive, Baltimore, Maryland, 21237, by April 15, 2010**. Failure to return this information in a timely manner will delay the processing of your employment and may affect your start date and delay pay.

Employment physicals are required and are scheduled between June 1, 2010 and June 11, 2010, by calling Bonnie Cohen-Finch, Recruitment Specialist at 443-777-7943. I urge you to schedule your appointment soon, so that you may find a time that is convenient for you. Please bring with you titer results for measles (rubeola), rubella, mumps, varicella (chickenpox) and Hepatitis B. If previously positive on a tuberculin skin test, a copy of that positive reading if available.

ID badges will be issued by Human Resources on the day of your physical, but will be distributed at orientation. Please remember to bring two forms of ID such as a driver's license, social security card, birth certificate, or passport with you at the time of your physical.

Again, welcome to Franklin Square Hospital Center. I look forward to working with you as you embark on this phase of your residency training. Should you have any questions, please feel free to contact me at 443-777-7298.

Sincerely,

Rhonna Murgatroyd  
Manager, Graduate Medical Education  
Franklin Square Hospital Center

**INSTRUCTIONS: FRANKLIN SQUARE HOSPITAL CENTER:**

**INTERN PACKET:**

The forms included in this packet are those which you must complete to initiate your employment processing. Please read the instructions carefully and complete all paperwork. **Keep the forms clipped together and mail the entire packet back to the Office of Graduate Medical Education, Franklin Square Hospital Center, 9000 Franklin Square Drive, Baltimore, Maryland 21237, no later than April 15, 2010.** Failure to return the enclosed information in a timely manner will delay the processing of your employment and may affect your start date and the pay period.

If you have any questions regarding these forms please call 443-777-7298.

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**OFFER LETTER and CONTRACT:**

The letter of offer and contract will be e-mailed to you for signature and return. It is important that you keep me informed of your current e-mail and mailing address.

**RESIDENT DEMOGRAPHIC INFORMATION:**

Complete entirely and **attach a current Curriculum Vitae, ECFMG Certificate (if applicable), and copies of any State licenses (If applicable). If your were previously enrolled in a graduate medical education training program, please attach a copy of residency certificate if available.**

**RELEASE OF INFORMATION:**

Please read the Immunity for Release of Information Form. Please print and sign your name at the bottom of the form.

**PAGER RESPONSIBILITY FORM:**

Please fill-in your name and the date on the top of the form. Your Company/Business Unit is Franklin Square Hospital, Department/Cost Center is the program you are entering. Please sign the bottom of the form and return it with the rest of this packet.

**BCLS/ACLS – AMERICAN HEART ASSOCIATION (AHA COURSES)**

All residents entering post-graduate training programs at Franklin Square Hospital Center are required to attend the AHA courses at the MedStar Simulation Center. Details on how to register for this course may be found by clicking on “SITE LMS”.

**POST-GRADUATE TRAINING VERIFICATION FORM:**

All residents who have completed or participated in previous U.S. postgraduate training must provide verification of this training to the Office of Graduate Medical Education at MedStar Health. Please forward this form to your residency program director and/or Office of Graduate Medical Education.

**\*\* A copy of your residency certificate must be attached.**

**ACKNOWLEDGEMENT AND CONSENT TO INFORMATION SYSTEMS**

This form must be completed to provide you with access to confidential electronic patient information. Page 1: Please print and sign your name in the spaces provided. The Company name is Franklin Square Hospital Center.

### **PRIMARY SOURCE VERIFICATION - MEDICAL EDUCATION VERIFICATION FORM:**

The medical education verification form must be completed by your medical school. Fill in your name and medical school in the spaces provided. **Please forward this form to your medical school for completion. This form should not be filled out prior to your graduation.** Please note that you will not be able to begin residency training until your medical school has completed and returned this form to the GME Office. Fax copies are **not** acceptable. All verifications must display original signatures and the school seal. If you are ECFMG certified, you will not need to have this form completed. Your ECFMG certificate serves as primary source verification.

### **LAB COAT REQUISITION**

Print name and select size.

### **EMPLOYMENT PHYSICALS, HUMAN RESOURCES AND ID BADGES**

**Employment physicals** must be completed prior to your scheduled contract start date of June 18, 2010. We strongly recommend that you schedule your physical as early as possible. Physicals will only be scheduled between June 1, 2010 and June 11, 2010. You may contact Bonnie Cohen-Finch, Recruitment Specialist, Human Resources to schedule a time that is convenient for you at **443-777-7943**. **At the time of your physical, please bring with you titer results for measles (rubeola), rubella, mumps, varicella (chickenpox) and Hepatitis B. If previously positive on a tuberculin skin test, a copy of that positive reading if available.**

### **NEW HIRE PACKET:**

Click on the link "New Hire Packet". Print and complete Items #1, 2, 3, 4, 5, 7, 8 and 10. Please keep these documents clipped together and separate from the intern packet. Questions regarding these documents may be directed to Bonne Cohen-Finch, Human Resources, at 443-777-7943.

### **UNLICENSED MEDICAL PRACTITIONER – Click on the link “Maryland Board of Physicians” and print the Unlicensed Medical Practitioner Registration Form.**

All residents in an accredited residency program must have an unlicensed medical practitioner number in the State of Maryland. Please complete Part I:

- (1) Name
- (2) Date of Birth
- (3) Social
- (4) Gender
- (5) Race
- (6) Medical Degree and Graduation
- (7) Licensure information
- (8) Degree
- (9) Local Address: Enter Department (Family Medicine, Internal Medicine or Obstetrics/Gynecology).

Franklin Square Hospital Center  
Office of Graduate Medical Education  
9000 Franklin Square Drive  
Baltimore, Maryland 21237  
Phone: 443-777-7298

- (10) Current Contract Year: 6/18/2010 – 6/23/2011 - Internal Medicine Residents  
6/18/2010 – 6/30/2011 – Family Medicine and OB/GYN Residents
- (11) Answer all questions
- (12) Sign and Date



**Have you completed prior Post-Graduate Training in the United States? Yes or No**

*\* If yes, please complete the Post-Graduate Training Verification Form, found in this packet*

Institution \_\_\_\_\_

Specialty \_\_\_\_\_

Dates Attended: \_\_\_\_\_

Name of Program Director: \_\_\_\_\_

Contact #: \_\_\_\_\_

**USMLE – (Step 1/Step 2 CK and CS required) – Please attach copies of score reports.**

Step 1 -	Date taken: _____	Score _____	Passed – Yes/No (circle one)
Step 2 CK	Date taken: _____	Score _____	Passed – Yes/No (circle one)
Step 2 CS	Date taken: _____	Passed – Yes/No (circle one)	
Step 3	Date taken: _____	Score _____	Passed – Yes/No (circle one)

**Complex – ( Level 1/Level 2 CE and PE required) – Please attach copies of score reports**

Level 1	Date taken: _____	Score _____	Passed – Yes/No (circle one)
Level 2 CE	Date taken: _____	Score _____	Passed – Yes/No (circle one)
Level 2 PE	Date taken: _____	Passed – Yes/No (circle one)	
Level 3	Date taken: _____	Score _____	Passed – Yes/No (circle one)

**Are you currently licensed in any other state of territory in the United States? Yes or No**

- If you answered yes, please indicate the state(s) and/or territories in which you are licensed.

State: \_\_\_\_\_ License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

State: \_\_\_\_\_ License #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Name of Spouse:** \_\_\_\_\_

**Contact # :** \_\_\_\_\_

- **PLEASE ENCLOSE A CURRENT CURRICULUM VITAE**

# MedStar Health

## PAGER RESPONSIBILITY FORM

HELPDESK/ALTIRIS INCIDENT # \_\_\_\_\_, Date \_\_\_/\_\_\_/\_\_\_

I, \_\_\_\_\_, Employee ID # \_\_\_\_\_

Hospital: \_\_\_\_\_

Business Unit/Company #: \_\_\_\_\_

Department/Cost Center #: \_\_\_\_\_

Received pager: # (410) - \_\_\_\_\_, Cap Code #: \_\_\_\_\_

Alpha-One Way: \_\_\_\_\_

T-900/M-90 Two-Way: \_\_\_\_\_

Digital/Numeric: \_\_\_\_\_

I understand that ordinary maintenance of the pager is the responsibility of MedStar Health Inc. **HOWEVER**, I am responsible for the disposition of the pager, should the pager be lost, stolen, damaged, or transferred to another person without authorization, I will be liable for the replacement cost.

Upon my departure from MedStar Health Inc. I will return the pager to my Department Head or designee. If I fail to return the pager, the replacement cost will be garnished from my final paycheck.

Replacement Cost: CURRENT REPLACEMENT FEES

Alpha-One Way      T-900/M90 Two Way      Digital/Numeric

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone: # (410) \_\_\_\_\_

\_\_\_\_\_  
Witness (Department Head)

**Please fax to 410-933-6325 Attn: Telecommunications or place form in pager returns bin. If not received within 10 business days of receiving the pager, the pager will be suspended until receipt of form.** Rev. 05/25/2007

## 2010-2011 Lab Coat Requisition

Three lab coats will be issued at the beginning of your residency.

We will order one lab coat in the size that you indicate below. A fitting will be held during orientation. Once proper fit is determined, the remaining lab coats will be ordered. Please indicate the proper spelling of your last name (i.e. Dr. Jones/Dr. Jones-Smith). Please note that we will only print Dr. XXXX on your lab coat.

If you have any questions regarding your lab coats please feel free to contact your Program Coordinator.

Sizes are ordered in small, medium, large, etc. Please use the sizing chart below. Example: If you are a women's size 10, you would order small; if you are a men's size 42, you would order large.

Unisex lab coat sizing guide: - (Style # AP4035)

Order Size	X-Small	Small	Medium	Large	X-Large	2XLarge	3XLarge
Women's Size	6 or 8	10 or 12	14 or 16	18 or 20	42 Or 44	46 or 48	50 or 52
Men's Size	32	34 or 36	38 or 40	42 or 44	46 or 48	50 or 52	54 or 56

Name: \_\_\_\_\_ Department: \_\_\_\_\_  
(Please print clearly)

Men's size: \_\_\_\_\_ Women's size: \_\_\_\_\_

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

Please return this form with your packet. Thank you.



Please attach additional sheets if necessary.

**Part III: Corrective Action (To be completed by the Reporting Institution):**

During the time noted, was this resident/fellow ever subject to any disciplinary action, including, without limitation, academic probation, repeat of training, extension of training, denial of credit, employment-related discipline (counseling, warnings or suspensions) and/or termination or dismissal?

YES \_\_\_\_\_ (if yes please explain) NO \_\_\_\_\_

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Please attach additional sheets if necessary.

**Part IV: Overall Evaluation (To be completed by the Reporting Institution):**

This evaluation should be based on demonstrated performance compared to that reasonably expected of a practitioner at his/her level of training, experience and background.

	POOR	FAIR	GOOD	SUPERIOR
Medical Knowledge	( )	( )	( )	( )
Professionalism	( )	( )	( )	( )
Practice Based Learning	( )	( )	( )	( )
Systems Based Practice	( )	( )	( )	( )
Patient Care	( )	( )	( )	( )
Interpersonal & Communication Skills	( )	( )	( )	( )

Please describe any weaknesses observed in any core competency area (attach additional sheets if necessary):

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Did the resident leave your program in good standing?

YES \_\_\_\_\_ (if yes please explain) NO \_\_\_\_\_

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\_\_\_\_\_  
Program Director (PRINT NAME) Date

\_\_\_\_\_  
Program Director (SIGNATURE) Date

Please Return to

Rhonna Murgatroyd  
Office of Graduate Medical Education  
Franklin Square Hospital Center  
9000 Franklin Square Drive  
Baltimore, Maryland 21237



Franklin Square  
Hospital Center

Centered on You  
*MedStar Health*

## User Confidentiality Agreement and Acknowledgement of Responsibilities

MedStar Health, Inc. and its subsidiaries (collectively, MedStar Health) are committed to the physical, technical and administrative security of its information technology resources. By my signature below, I understand that my access and use of all MedStar Health information technology resources, including but not limited to, access and use of the MedStar Health network, hardware, and software (collectively "systems") is a privilege and that such access and use are subject to all applicable legal requirements as well as all applicable MedStar Health policies, procedures, and requirements and the applicable policies, procedures, and requirements of the MedStar subsidiary which authorizes my system access and use.

As a condition of my access, I agree to maintain the confidentiality of all MedStar Health confidential business information which I may have the ability to access, including but not limited to, all personnel information, billing and financial information, patient data or medical information, promotional and marketing program information, strategic planning data, business plans, computer passwords/access rights, privileged materials, trade secrets, intellectual property, and other proprietary information relating in any way to MedStar Health.

I further understand and agree that even though I may be granted access to systems which contain large quantities of data as part of my job responsibilities or role within MedStar ("Role-Based Access"), I am only permitted to access, use, disclose specific information as necessary to perform my job function or complete my responsibilities. I understand this means that I am not permitted to access or use any component of the system if I do not have a legitimate professional need to have such access and it is my responsibility to terminate access to any systems I do not need.

In addition, I understand that I am only permitted to access, use and disclose information from the system and its components, or its connected systems, if it is for a purpose permitted under applicable laws and policies ("Purpose-Based Access"). I understand this means that even if when my role would permit me to have access to the system, I am only permitted to access, use, or disclose the information if it is for an authorized and permissible purpose.

I understand that these obligations apply whether the information is held in electronic or any other form, and whether the information is used or disclosed electronically, orally, or in writing.

**Acknowledgement of Responsibilities.** I understand and agree that:

### Administrative, Technical, and Physical Safeguards

The User ID and Password assigned to me are unique and non-transferable and that I will not share my User ID or password with any other individual, permit another person to perform any functions while logged into a system under my User ID or Password, nor will I perform any function using a system under another person's User ID or Password.

I will take appropriate measures to protect my User ID and Password and that I am responsible for all information accessed, used, or altered with the use of my User ID and Password.

I understand that my approved access and use of MedStar's systems is limited to only those systems necessary to perform my job duties or as permitted because of my role and that I must request deactivation of any systems not necessary to perform my duties or responsibilities.

I agree to logoff the system when I leave a workstation and to take such other reasonable steps as are necessary to maintain the physical security of my workstation to ensure that unauthorized persons cannot view or access any confidential, proprietary, or identifiable patient information that I may have

access to by virtue of my responsibilities or access rights.

I understand that my approved access and use may be actively recorded, monitored, and/or audited without prior notice (including Internet and e-mail account usage) and that MedStar Health reserves the right to monitor, review, and record individual user system activities (including, but not limited to, the use of personal e-mail accounts). MedStar Health may permit other business partners or law enforcement to monitor, uses, or record such information as permitted or required by law.

Acceptable Uses and Disclosures

I agree that acceptable use of MedStar Health systems and the disclosure of information from those systems include only those activities which foster's MedStar Health's clinical, research, educational, and business purposes in a manner which promotes the vision, mission and values of MedStar Health and are consistent with MedStar's Code of Conduct and legal requirements.

I agree to access, use, or disclose system information only in the performance of my duties, where required by or permitted by law, and only to persons who have the right to receive that information.

I agree that I will not copy, download, print, transmit information in any format, for myself or for any other person, except as I am required to fulfill my responsibilities.

When using or disclosing information, I will use or disclose only the minimum information necessary.

I understand that prohibited uses of MedStar's systems (including e-mail and Internet use) include, but are not limited, to any use that:

Involves illegal activity or threatens MedStar, its users, or its systems in any way,

Interferes with the acceptable use of other MedStar users,

Is in violation of any MedStar Health policy, procedure or requirements.

I understand that acceptable personal uses of MedStar systems (including e-mail and Internet use) are severely limited to Activities:

Incidental to an acceptable MedStar business use (such as coordinating work and family schedules),

That do not cause MedStar to incur additional expenses or interfere with my productivity, or any other clinical or business activities,

That does not violate any MedStar policies, procedures or requirements.

Training and Education

I understand that system education and training may be mandatory for each system accessed and that it is my responsibility to fulfill all mandatory training and education requirements necessary for my role as a condition of my system access.

Reporting Requirements

I agree to immediately notify my supervisor and the MedStar Health Information Systems Security Office via the Help Desk (1-410-933-HELP)

If I suspect that someone has gained unauthorized access to my User ID or Password.

If any hardware or software used to access MedStar systems is lost or stolen.

**By my signature I understand and agree that my rights to access and use MedStar's system may be immediately terminated without further notice for breaching any terms of this agreement and that such a breach may result in personal liabilities, including but not limited to (as applicable): disciplinary actions up to and including termination of employment, loss of professional privileges, criminal prosecution, civil litigation, referral to appropriate law enforcement authorities, referral to regulatory or licensure authorities, or other remedies as deemed appropriate by MedStar Health.**

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Signature

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Date

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Print Name

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Facility/Department



**MedStar Health – Baltimore Division  
Franklin Square Hospital Center  
Office of Graduate Medical Education  
Verification of Medical Education**

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It is hereby certified that \_\_\_\_\_ matriculated in Medical  
Name

School on \_\_\_\_\_ and received a diploma from \_\_\_\_\_  
Institution

conferring the degree of Doctor of Medicine on \_\_\_\_\_.  
Date

School Seal

\_\_\_\_\_  
Signature of Dean or Registrar

Please return to:

Rhonna Murgatroyd  
Program Manager, Graduate Medical Education  
Franklin Square Hospital Center  
9000 Franklin Square Drive  
Baltimore, Maryland 21237

**Please note that this form cannot be completed prior to the actual date of graduation.**