This Application is for **Non-employed Clinical Assistants** (RN, dental assistant, orthotist, etc) who wish to assist a supervising physician at one or more of our facilities. Advanced Practice Nurses (CRNA, NP, PA, etc) must apply through the SJMHS Credentialing Department, regardless of employment status. Return completed application to:

SJMHS Human Resources, Attn: Tonia Schemer (schemert@trinity-health.org)
5301 East Huron River Drive
P.O. Box 995
Ann Arbor, MI 48106
Phone: (734) 712-5505
Fax: (734) 712-1199

APPLICATION MUST BE RETURNED AT LEAST 60 DAYS PRIOR TO START DATE

Name: ____ Degree: ________
Last First Middle Suffix

If you have ever received training, practiced medicine, been licensed or certified under a different name, please indicate name and dates name was used:

Name(s) ____ Dates ____________________

What is your start date? (Date in which you plan to begin seeing patients in the hospital). ____________________

Complete all that apply:

Facility	Department/ Specialty	AHP Category (RN, OMSA, CPO, etc)	Supervising Physician
❑ St. Joseph Mercy Livingston Hospital			
❑ St. Joseph Mercy Saline Hospital			
❑ St. Joseph Mercy Hospital			

SECTION I. IDENTIFICATION DATA

These responses are required for identification and regulatory reporting purposes only.	
Date of Birth: *The Age Discrimination in Employment Act prohibits discrimination on the basis of age with respect to individuals who are at least forty years of age.*	Place of Birth: (City, State, Country)
Social Security Number:	
Optional Information	
Gender: M ☐ F ☐	Language(s) Spoken/Written (other than English):
Marital Status:	
Spouse's Name:	Citizenship:

Home Address: ____ Phone: ____________________________

____ Home Fax: __________________________

E-Mail Address: __________________________________ Pager: ____________________________

SECTION II. OFFICE INFORMATION

Primary Office Name: ____

Address: ____

Office Telephone: ______________________

Office Fax: ______________________

SECTION III. EDUCATION – COMPLETE ADDRESS MUST BE SUPPLIED

School/Program ____ Degree ___________ Graduation Year ________

____
Address City State Zip

SECTION IV. PROFESSIONAL PRACTICE HISTORY – COMPLETE ADDRESS & DATES MUST BE SUPPLIED

Please list below, in chronological order, all hospital affiliations, and practice sites since completion of professional education.

HOSPITAL or GROUP NAME & ADDRESS	SUPERVISING PHYSICIAN NAME & ADDRESS	POSITION (NP, PA, CNM, CP, etc)	DATES OF AFFILIATION From-To mm/dd/yy
1.			
2.			
3.			
4.			
5.			

Have you ever been convicted of and/or pled guilty to any crime or offense (other than minor traffic violations)?
Yes ☐ No ☐

If yes, please explain:____

Lapses in professional history - *Explanations must be provided for gaps in professional history*	
1. Activity:	Dates:
2. Activity:	Dates:
3. Activity:	Dates:

Attach additional sheet to provide additional information on any of the above

SECTION V. CERTIFICATION, LICENSURE and INSURANCE INFORMATION

Name of Certification Board:____

Certification Year: _____________ Re-Certification Year: __________ Expiration Year: ______________________

Michigan Professional License # _______________________ Expiration Date: ______________________________________

Have you had/Do you have **out-of state license**(s)? Yes ☐ No ☐

If yes, list states (other than Michigan) in which you are currently or previously have been licensed:

State	License #	Expiration	Type of License (RN, PA, etc)
____________	____________________________	__________________	____________________

Certifications: BLS Expiration Date: ___________ ACLS Expiration Date: _________ ATLS Expiration Date: ________

Current Professional Liability Carrier: ____

____

Address City State Zip

Type of Policy: (Occurrence, Claims Made) ____________________________ Limits (Occurrence/Aggregate): _______/_______

Policy Number: _______________ Date of Issue: __________ Expiration Date: _______________

SECTION VI. REFERENCES

Please provide the name and complete mailing addresses for *specified references below* who have direct knowledge of your current clinical ability, ethical character, health status and ability to work with peers. References should be individuals who have personally observed your work and/or served in a supervisory capacity. Do not list current partner or relative.

Current Supervisor		
Name:	Phone:	Fax:
Address/City/State/Zip:		
Physician Reference		
Name:	Phone:	Fax:
Address/City/State/Zip:		

SECTION VIII. ADDITIONAL INFORMATION

☐ Yes ☐ No Have you ever been sanctioned by the Office of Inspector General of the Department of Health and Human Services (HHS/OIG) or the Government Services Administration (GSA) or excluded or suspended from participation in any federal or state health care program?

☐ Yes ☐ No Can you certify that you have NOT been debarred or excluded from participation in Medicare, Medicaid or any other federally or state funded healthcare program(s) and have NOT been convicted of a healthcare related criminal offense?

SECTION IX. AGREEMENT FORM

ATTESTATION STATEMENT

I fully understand that any falsifications from or omissions to this application could constitute cause for summary suspension. I attest that all information submitted by me in this application is true and complete to the best of my knowledge and belief.

I understand that I cannot practice at the hospital(s) until I am notified that I have satisfactorily met the criteria of the Saint Joseph Mercy Health System. I further understand that I must complete a System orientation, Department-specific competency evaluation, Department orientation, and complete all Healthstream courses as assigned before non-employed status will be granted.

______________________________ ______________

Signature Date

____

Print Name

SECTION X. Saint Joseph Mercy Health System / TRINITY HEALTH
CONFIDENTIALITY AND NETWORK ACCESS AGREEMENT

The following rules for Confidentiality and Network Access apply to all non-public patient and business information (Confidential Information) of St. Joseph Mercy Hospital, St. Joseph Mercy Livingston Hospital, St. Joseph Mercy Saline Hospital, St. Mary Mercy Hospital, Trinity Health, and related organizations. The rules also apply to the non-public and business information of joint ventures, or of other entities and persons collaborating with these organizations, to which the user has access. As a condition of being permitted to have access to Confidential Information relevant to my job function or role I agree to the following rules:

1. Permitted and required access, use and disclosure:

- I will access, use or disclose Confidential Patient Information (PHI) only for legitimate purposes of diagnosis, treatment, obtaining payment for patient care, or performing other health care operations functions permitted by HIPAA and I will only access, use or disclose the minimum necessary amount of information needed to carry out my job responsibilities.
- I will access, use or disclose Confidential Business Information only for legitimate business purposes of the hospitals of the Saint Joseph Mercy Health System or Trinity Health.
- I will protect all Confidential Information to which I have access, or which I otherwise acquire, from loss, misuse, alteration or unauthorized disclosure, modification or access including:
    - making sure that paper records are not left unattended in areas where unauthorized people may view them;
    - using password protection, screensavers, automatic time-outs or other appropriate security measures to ensure that no unauthorized person may access Confidential information from my workstation or other device;
    - appropriately disposing of Confidential Information in a manner that will prevent a breach of confidentiality and never discarding paper documents or other materials containing Confidential Information in the trash unless they have been shredded
    - safeguarding and protecting portable electronic devices containing Confidential Information including laptops, smartphones, PDAs, CDs, and USB thumb drives.
- I will disclose Confidential Information only to individuals, who have a need to know to fulfill their job responsibilities and business obligations.
- I will comply with Saint Joseph Mercy Health System/Trinity Health's access and security procedures, and any other policies and procedures that reasonably apply to my use of the computer systems and/or my access to information on or related to the computer systems including off-site (remote) access using portable electronic devices.

2. Prohibited access, use and disclosure:

- I will not access, use or disclose Confidential Information in electronic, paper or oral forms for personal reasons, or for any purpose not permitted by Saint Joseph Mercy Health System/Trinity Health policy, including information about co-workers, family members, friends, neighbors, celebrities, or myself. I will follow the required procedures at Saint Joseph Mercy Health System to gain access to my own PHI in medical and other records.
- I will not use another person’s, login ID, password, other security device or other information that enables access to Trinity Health's computer systems or applications nor will I share my own with any other person.
- If my employment or association with Saint Joseph Mercy Health System/Trinity Health ends, I will not subsequently access, use or disclose any Saint Joseph Mercy Health System/Trinity Health Confidential Information and will promptly return any security devices and other Trinity Health property.
- I will not engage in any personal use of Saint Joseph Mercy Health System Hospital computer systems that inhibits or interferes with the productivity of employees or others associated with Saint Joseph Mercy Health System/Trinity Health’s operations or business, or that is intended for personal gain;
- I will not engage in the transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate or in violation of the mission, values, policies or procedures of Trinity Health;

- I will not utilize the Saint Joseph Mercy Health System/Trinity Health network to access Internet sites that contain content that is inconsistent with the mission, values and policies of the Saint Joseph Mercy Health System/Trinity Health.

3. Accountability and sanctions:

- I will immediately notify Saint Joseph Mercy Health System/Trinity Health Security Official or Privacy Official if I believe that there has been improper/unauthorized access to the Trinity Health network or improper use or disclosure of confidential information in electronic, paper or oral forms.
- I understand that Saint Joseph Mercy Health System/Trinity Health will monitor my access to, and my activity within, Trinity Health's computer system, and I have no rightful expectation of privacy regarding such access or activity.
- I understand that if I violate any of the requirements of this agreement, I may be subject to disciplinary action, my access may be suspended or terminated and/or I may be liable for breach of contract and subject to substantial civil damages and/or criminal penalties.
- If I lose my security device I will report the loss to the Trinity Health Resolution Center immediately and I may be charged for its replacement.

4. Software use:

- I understand that my use of the software on Trinity Health's network is governed by the terms of separate license agreements between Trinity Health and the vendors of that software.
- I agree to use such software only to provide services to benefit Trinity Health.
- I will not attempt to download, copy or install the software on any other computer.
- I will not make any change to any of Trinity Health's systems without Trinity Health's prior express written approval.

5. Network:

- I understand that access to Trinity Health's network is "as is", with no warranties and all warranties are disclaimed by Trinity Health.
- Trinity Health may suspend or discontinue access to protect the network or to accommodate necessary down time. In an emergency or unplanned situation Trinity Health may suspend or terminate access with out advance warning.
- Trinity Health may terminate this agreement, user access and use of Confidential Information at any time for any reason or no reason.

6. Employer acceptance of responsibility for an individual with access to Confidential Information:

<u>(Applies to physicians/physician practices; other individual or facility providers; a vendor that is not a business associate; payers; any other unaffiliated organization).</u>

- I accept responsibility for all actions and/or omissions by my employees and/or agents
- I agree to notify the Trinity Health Resolution Center within 5 business days if any of my employees or agents who have access to Trinity Health systems or applications no longer need or are eligible for access due to leaving my practice/company, changing their job duties or for any other reason.
- I agree to report any actual or suspected privacy or security violations made by my employees and/or agents to the Saint Joseph Mercy Health System/Trinity Health Privacy Official or Security Official.
- I understand that the Saint Joseph Mercy Health System/Trinity Health may terminate my employee and/or agent's access.

PRACTITIONER SIGNATURE

If there are any items in this agreement that I do not understand I will ask my supervisor or other appropriate contact person for clarification. My signature below acknowledges that I have read, understand and accept this agreement and realize it is a condition of my employment or association with Trinity Health. I also acknowledge that I have received a copy of the Confidentiality and Network Access Agreement.

Practitioner Signature: ____ Date: ___________

Print Name: ____

Department/Section: ____

Background Check Consent and Disclosure

As a part of our on-boarding process, please follow the below instructions on how to complete a background check consent and disclosure form.

- Go to www.applicationstation.com
- Enter code: **THKJSJM3**
- Register with the Application Station website by clicking 'SIGN UP NOW'
- Sign in using the username and password you registered with.

The Application Station website will take you through step-by-step instructions and will request information needed to perform a background check. Please be sure to enter all necessary and accurate information. At the end of your application you will be asked to authorize the background check by reviewing the releases, entering your name, checking the agree box, and dating the application with the day you're completing the application and your birth date. When the final submit is selected, the system will inform you that no changes can be made once the document is submitted

If you need additional instructions or have questions, please contact your HR Employment Representative.