Restoring Hope and Freedom
Mary Free Bed
Rehabilitation Hospital

# *Visiting Resident Application*

*BASIC INFORMATION:* Date:_____

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Social Security#: _____ Email Address: _____

DOB: _____ Cell Phone: _____

*IN CASE OF EMERGENCY:*

Name _____

Address _____

Phone (home) _____ (work)_____ (Cell) _____

*INSTITUTION/PROGRAM INFORMATION*

Name of Institution & Program (if applicable): _____

Institution Address: _____

Contact person: _____ Title _____

Phone/Email/Fax: _____

***ROTATION REQUESTS***

**Name of rotation:**

_____ Start/End Dates: _____

_____ Start/End Dates: _____

_____ Start/End Dates: _____

Restoring Hope and Freedom
Mary Free Bed
Rehabilitation Hospital

**EXHIBIT A**

HOSPITAL
**CLINICAL EXPERIENCE PARTICIPATION AGREEMENT**

I, _____ ("Resident"), in consideration for participating in the clinical training provided by Mary Free Bed Rehabilitation Hoapital ("Hospital") and through my participation in Hospital's clinical training program, hereby agree to the following:

1. Patient Confidentiality. I understand that the health information of Hospital's patients is confidential which means that it cannot be revealed or discussed with other patients, friends, relatives, or anyone else outside of the Hospital care environment. In other words, a patient's personal and medical information can only be discussed in private with appropriate individuals who have a medical and/or business related need to know, whether on duty or off. **I hereby certify that I will not release or disclose patient information, unless my job requires it, and then I will disclose only the minimum necessary patient information needed to carry out my responsibilities for Hospital.**

2. Non-employee Status. I acknowledge that the clinical training received by me from Hospital shall be received as a resident of Sponsoring Instituion, as a part of my professional training, and not as an employee of Hospital. **I understand that as a participant in this clinical training program, I shall not be entitled to compensation or employee benefits, nor shall I be considered an employee of Hospital for purposes of unemployment compensation, minimum wage laws, workers' compensation, income tax withholding, Social Security, or any other purpose.**

3. Compliance with Policies. I will comply with all applicable standards of care, policies, procedures, rules and regulations of Hospital, and the instructions of Hospital supervisors. I will further observe conservative and professionally appropriate modes of dress, behavior and grooming at all times.

4. Participation. I will participate in clinical training in accordance with the instructions of Hospital supervisors.

5. Required Tests. I will provide proof of a TB skin test and/or chest x-ray as required by the Hospital, and such other health-related testing and immunizations as may be required by Hospital or by the Michigan Department of Public Health or the Occupational Health and Safety Administration. I understand that if I refuse any required immunizations or health-related testing, I may be terminated from the clinical training program at Hospital. In the event, however, that I refuse the Hepatitis B vaccination, I will not be terminated from the Program if I promptly sign a written waiver expressly holding Hospital Harmless for any Hepatitis B exposure or infection that might result from clinical training at Hospital.

6. Release of Liability-Clinical Education Program. I understand and acknowledge that Hospital has the right to take certain actions, including but not limited to, the right to suspend or terminate me from, or limit my participation in, the clinical training program, or to

evaluate me unfavorably, if in its exclusive judgment I have failed to observe applicable policies, procedures, rules, regulations, or the instructions of Hospital supervisors, or have compromised the standard or quality of patient care or the safety of patients, or for other reasonable cause, including the failure to follow appropriate modes of dress, grooming and behavior. **I hereby voluntarily release Hospital and their employees, agents and medical staff from any and all liability based on such actions.**

7. Release of Liability-Academic Program. I understand and acknowledge that School shall have complete control over all academic aspects of the clinical training, including but not limited to, admissions, administration, faculty appointments, program design, grading, examinations and evaluations. **I hereby voluntarily release Hospital and their employees, agents and medical staff from any and all liability based on such actions.**

8. I have read this Participation Agreement carefully and have had sufficient opportunity to ask questions and have it explained to me before signing it.

_____

Participant's Signature

_____

Participant's Printed Name

Date:_____

**User Maintenance: Physician Information Form**

**Fill this form out including patient name and fin# and employee info at the bottom. Then email to helpdesk.*

**Patient Info**

| **Patient Name:** | **FIN #:** |
|---|---|

**New Physician Info**

| | |
|---|---|
| **Last Name:** | |
| **First Name:** | |
| **Middle Initial/Name:** | |
| **Title (MD, DO, PhD, PsyD, PA-C, NP, etc):** | |
| **Taxonomy Number:** | |
| **NPI Number:** | |
| **Office Street Address1:** | |
| **Office Street Address 2:** | |
| **City:** | |
| **County:** | |
| **State** | |
| **Zip code** | |
| **Office Phone Number** | |
| **Office Fax Number** | |

| **IT Use Only:** | | **Employee Information** |
|---|---|---|
| ☐ Physician Built in Dictionary | ☐ Form sent back to originator | This form was emailed by: |

Mary Free Bed
Rehabilitation Hospital

235 Wealthy SE
Grand Rapids, MI 49503-5299
616.242.0300 • 800.528.8989

# Parking and Identification Badge Application

**Employee Name** _____ **Start Date** _____

**ID & Parking Sticker** ☐ **ID Only** ☐ **Parking Sticker Only [ ]**

**Type of badge holder:** **Lanyard** **Reel** **Clip**

## ID CARD INFORMATION

Employee Number _____

Credentials _____ Title _____

Department _____

## VEHICLES INFORMATION

1. Make/Model/Color /Year _____

   License Plate Number _____

2. Make/Model/Color /Year _____

   License Plate Number _____

I have been issued an MFB employee ID & Kronos Swipe Card for timekeeping purposes, or an MFB Volunteer/Student ID Card. I understand that per the MFB Policy I must wear my MFB picture ID in such a way that is easily visible. Furthermore, the ID must not be altered or defaced. I understand that if I lose or damage my card, there will be a Non-negotiable $5.00 replacement fee.

Employee/Volunteer/Student Signature _____ Date

For Office Use Only – Do Not Write Below This Line

1. Vehicle Sticker Number: _____
2. Vehicle Sticker Number: _____
3. ID Card Number: _____
4. Picture Number: _____
5. Deliver ID Card/Sticker to Manager/Supervisor: _____
   (DO NOT DELIVER TO H.R. UNLESS REQUESTED)

Parking Database _____ Security Access System _____ Nursing Dept. Access _____

Security Officer Initials: _____ Date Entered: _____

Mary Free Bed
Rehabilitation Hospital

235 Wealthy SE
Grand Rapids, MI 49503-5299
616.242.0300 • 800.528.8989

# Confidentiality of Information Agreement

As part of MFB's organizational values of customer focus and trust/trustworthiness, protecting confidential information is required by all employees, volunteers, students, contracted agents, business associates and researchers.

I understand and accept that as an employee, volunteer, student, contracted agent, business associate, or researcher, access to patient and hospital business information is required for me to do my job at Mary Free Bed Rehabilitation Hospital (MFB). I am only permitted to access patient information to the extent necessary for me to provide patient care and/or perform my duties. I will treat all patient, physician, employee and hospital business information acquired during the course of my work as strictly confidential. This confidential information may be of a financial, personal or medical nature.

I understand that "confidential" means that patient information must not be revealed or discussed with other patients, friends, relatives, or anyone else outside of MFB. A patient's personal and medical information can only be discussed in private with appropriate individuals who have a medical and/or business related need to know.

I will not release or disclose patient information unless my job requires it. I will disclose only the minimum necessary patient information needed to carry out my responsibilities. I understand that retrieving, viewing or printing information (computerized or paper) on other patients such as friends, relatives, neighbors, celebrities or co-workers is a breach of confidentiality and may subject me to immediate termination of employment as well as civil and/or criminal penalties.

I understand that I could be personally liable for litigation and fines and may expose the hospital to litigation and fines if I access, discuss or release information concerning a patient or employee beyond what is necessary to do my job.

In response to this, **I agree <u>not</u> to**:

- Disclose, discuss, or otherwise reveal any information regarding a patient except that which is required in the course of performing my job duties
- Disclose, discuss or otherwise reveal a patient's condition in public areas (such as elevators, cafeteria and hallways)

To promote confidentiality in the workplace, **I agree <u>not</u> to**:

- Use a code, access a file, or retrieve any stored information unless it is required in the course of performing my job duties
- Share or disclose my computer user ID or password or use another staff member's computer ID or password (except with IT staff who are troubleshooting computer problems)
- Log on to my computer and allow another user to access information
- Save Protected Health Information onto my laptop or removable media (such as memory stick, CD, floppy disk, etc.) without written permission from the HIPAA Privacy or Security Officer
- Send patient identifiable information in an email outside of MFB

I acknowledge, understand and accept responsibility in maintaining confidentiality and realize it is a condition of my employment/association with MFB. Unauthorized disclosures of patient information or hospital business information may result in the termination of my employment or association with MFB.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| **Date** | **Printed Name** | **Signature** | **Department/Program** |

**Please check one:**
**[ ] Employee [ ] Volunteer [ ] Student [ ] Other:** _____

# STANDARDS OF BEHAVIOR: IT TAKES TEAMWORK

CLIMB TO EXCELLENCE

Mary Free Bed Rehabilitation Hospital

As Mary Free Bed climbs to excellence, I will provide the Best Patient Experience, Best Employee Experience and the Best Community Experience by following these Standards of Behavior.

## CARE

**I will:**

- Help patients and visitors find their way by escorting and/or finding someone who is able to assist
- Show concern and empathy in every interaction
- Remain calm and caring at all times

## COMMUNICATION

**I will:**

- Be intentional to acknowledge others and greet them with a smile at all times
- Interact with patients using AIDET:
  - Acknowledge the patient
  - Introduce myself by name and role
  - Explain duration
  - Explanation of services and results
  - Thank them
- Communicate in a manner that reflects caring, dignity, compassion and promotes a positive work environment
- Communicate at eye level
- Give feedback that builds confidence, recognizes accomplishments and encourages others to overcome challenges
- Collaborate and problem-solve together, assuming the good intentions of others
- Adhere to Mary Free Bed policies on phone and email etiquette

## RESPECT

**I will:**

- Ask permission to enter before going into a patient's room or a co-worker's workspace
- Ask "is there anything else I can help you with?" after every encounter
- Show support for my co-workers by being punctual and ready to work
- Listen carefully during all interactions: I will not assume I already know
- Have awareness of my surroundings and those that may be affected by my behaviors or actions
- Begin and end on time for meetings and appointments and provide a timed agenda

## PROFESSIONALISM

**I will:**

- Demonstrate professionalism in appearance and actions
- Wear nametag and keep visible at chest level
- Speak positively of Mary Free Bed and co-workers
- Be accountable/follow through on what I say I am going to do
- Be the best I can be with patients and my co-workers all day, every day
- Actively participate in achieving individual, departmental and organizational goals
- Take initiative to continuously enhance skills and expertise
- Be flexible and embrace change, knowing that change for improvement is vital to our success

## SAFETY AND QUALITY

**I will:**

- Address safety issues immediately by attending to them myself and/or asking for help
- Actively maintain a clean and safe environment
- Routinely explore best practices and new ways to be more effective, efficient and safe
- Adhere to Mary Free Bed infection control policies, including washing in and washing out
- Support and champion a culture of safety in my work at Mary Free Bed

Employee Name:_____ Date:_____

Department: _____

# A.I.D.E.T Student Agreement

**The Benefits of using A.I.D.E.T**:

-Improves patient and customer perception of their care and the service they receive
-Helps reduce anxiety, improving outcomes
-Builds customer and employee loyalty
-Ensures all service providers are delivering consistent empathy, concern and appreciation
-Improves teamwork

**What is A.I.D.E.T?**

**A**cknowledge
**I**dentify
**D**uration
**E**xplanation
**T**hank you

**How to use A.I.D.E.T:**

-**A**cknowledge: knock before entering, acknowledge patient/person by name, acknowledge everyone in the room with eye contact, a smile, and a "hello", take the initiative to make eye contact, smile, and say "hello" in the hallways

-**I**ntroduce: Provide your name and role on the team, validate the name of the person, tell him/her if you have any special skills and how long you have been doing what you're doing, manage up (talk about yourself, coworkers, departments or company in a positive way)

-**D**uration: Say how long you will be working with the person, how long the delay will be, how long the process will take, how long the person will be on hold.

-**E**xplanation: Use words the patient/person will understand, say what you're about to do before you do it and why, say what will happen and what to expect, always offer and opportunity to ask questions after you explain something

-**T**hank you: Show appreciation, provide a positive closing, and ask what other questions the patient/person has, ask "what more can I do for you before you leave?"

**Example Script:**

| | | |
|---|---|---|
| A | Acknowledge | Good Morning, how are you doing _____? |
| I | Introduce | "My name is _____ and I will be your _____ today. I am a part of an entire team who will help you through your rehabilitation here at Mary Free Bed. I have been a _____ for _____ years and enjoy being part of the _____ team. I am going to take very good care of you this morning." |
| D | Duration | "I need about 20 minutes to complete your history and assessment. Do you have any questions for me before we begin?" |
| E | Explanation | "I'm going to ask you several questions which are part of the admission process. This will help me plan your care and next steps for me and other members of our team." |
| T | Thank You | "Thank you for your patience in answering my questions. I believe you may have already met _____, your _____. He/She is amazing to work with and we are glad you are here for your rehabilitation care." |

Name: _____

Signature: _____

Date Signed: _____

Restoring Hope and Freedom
Mary Free Bed
Rehabilitation Hospital

**Statement of Good Standing**

**Name:**_____

**SECTION II - TO BE COMPLETED BY RESIDENT'S PROGRAM DIRECTOR**

☐YES ☐NO The above-named Resident is currently in good standing.

☐YES ☐NO The above named Resident has the required academic background and skills necessary to participate in and is approved to take the requested rotation.

If there have been any academic/clinical performance, liability, disciplinary, or other problems with this Resident, please explain:

_____agrees to incur the cost of the above-named Resident's
*Name of Resident's Program*
salary and benefits during his/her rotation(s) at Mary Free Bed Rehabilitation Hospital.

_____agrees to provide professional liability coverage for the
*Name of Resident's Program*
above-named Resident during his/her rotation at Mary Free Bed Rehabilitation Hospital. (Mary Free Bed Rehabilitation Hospital does not provide liability coverage for visiting Residents)

***Proof of Professional Liability Insurance must be attached to this application***

I agree to all the preceding terms and affirm that all submitted information is correct:

_____
*Program Director's Signature* *Date*

_____
*Printed Name*

Restoring Hope and Freedom
Mary Free Bed
Rehabilitation Hospital

**Visiting Resident Application Checklist**

☐ I understand submission of an application does not constitute approval of rotation request.

☐ Copies of background check and drug screen from your current residency program

☐ I have attached copies of all required documentation, including but not limited to:

- Current Educational Limited or Permanent Medical and Controlled Substance License
- ERAS Application
- ECFMG Certificate *(if international medical school graduate)*
- Medical School Diploma
- Certificate of Professional Liability Insurance which will provide coverage while rotating with Mary Free Bed Rehabilitation Hospital (Mary Free Bed Rehabilitation Hospital does not provide liability coverage for visiting residents)
- BLS and ACLS Certificates

☐ I have attached documentation confirming my immunization history including but not limited to Whooping Cough (DPT or TDaP), MMR, Rubella, Rubeola, Varicella, Hepatitis B, Flu, and TB.

- I hereby release Mary Free Bed Rehabilitation Hospital and its employees, staff and agents from all legal responsibility or liability that may arise from the disclosure of the information set forth relating to my file.

☐ If accepted for a rotation at Mary Free Bed Rehabilitation Hospital, the Resident agrees to the following:

- Resident will complete any required institutional and rotation-specific orientations.
- Resident will comply with all Mary Free Bed Rehabilitation Hospital and specific training site policies.
- Resident will perform assigned duties to the best of his/her ability.
- Resident will provide his/her own housing and transportation.
- Resident will maintain patient confidentiality by following all HIPAA regulations.

☐ Submit completed application **no less than 90 days in advance of rotation start date** via mail to: Lisa Vincent, Residency Coordinator, 235 Wealthy St SE, Grand Rapids, MI 49503. Email to Lisa.Vincent@maryfreebed.com or fax to (616) 840-9665.

**I authorize my Program Director to release to Mary Free Bed Rehabilitation Hospital all performance and health information necessary to complete SECTION II of this application.**

*Applicant's Signature* *Date*