DENVER HEALTH
OFFICE OF EDUCATION

RESIDENT/FELLOW BADGE FORM

Name: First (print legibly)	Middle	Last
	6/23/2021	N/A
Social Security	Date of Hire	
UCD RESIDENT/FELLOW	**Internal Medicine**	**N/A**
Job Title	Department Name	Unit/Pavilion Number

New & Replacement Badge Times—Monday through Friday: 7:30am –11am and 11:30am –3:20pm

Payment for replacement badges may be made: 1) To the DH Department Coordinator by cash or check only **or** 2) At the cashier's office in the main hospital by cash, check, or credit card (except for American Express)
If you pay at the cashier's office, you will need to bring your receipt with you as proof of payment for your badge.

Hire Status: *(check one)*
__X__Full Time _____Volunteer
_____Part Time _____ Student
_____Intermittent _____Contract/Temp

SMART CARD: Y____ or N___

PINK CARD**: Y____ or N___

**For any resident/fellow working with children, often FM, OB/GYN, pediatrics. Office of Education will confirm with department.

Reason for I.D: (*check one)*
_____**New Hire** or _____**Rehire**
_____**Lost** (Must show picture I.D. and pay for replacement, check Lawson, must go to Engineering to have card recoded)
_____**Damaged** (Free if employee presents old badge, no badge form required, check Lawson)
_____**Transfer/Promotion** (Free if employee presents old badge-must show new job title in Lawson)
_____**Name Change** (Free if employee presents old badge; must present social security card in new name)
__X__Resident* _____**Contract** _____**Volunteer** ______**Student** _____**Summer Youth**
(*Anyone who is not on DH payroll: Residents, Contract/Temporary employees, Volunteers, Students and Summer Youth must present a picture I.D. in order to receive a badge.)

This card is to be used ONLY by the above individual for identification and for badging in and out of authorized areas. Any other use of this card may result in disciplinary action in accordance with Career Service Authority Rules and/or Denver Health and Hospital Authority Principles and Practices.

I understand that the badge I will receive is the property of Denver Health and Hospital Authority and must be surrendered upon the request of my supervisor. I understand that I will be subject to discipline in accordance with applicable disciplinary rules if I allow any other person to use my badge for any reason. If I lose or damage the badge other than normal wear and tear, I will be charged a replacement fee of $15.00.

_______________________ Resident/Fellow Signature

__________ Date

Tereza Guedes
DH Supervisor's Name

Tereza Guedes
DH Supervisor's Signature

PROGRAM COORDINATOR TO SCAN/EMAIL TO: OfficeofEducation@dhha.org

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RESIDENT/FELLOW INFORMATION SERVICES (IS) ACCESS REQUEST

MIS/MRD USE ONLY:
Network Sign-on: ____________________
MRI User ID: ____________________
Date Given to User: ____________________

(PLEASE PRINT LEGIBLY)

Resident/Fellow Name:	Resident/Fellow Degree (MD, DO, etc)	Birthdate: / /	SS#:
Name of School: University / Graduate Medical Education		Expected Completion Date: 6/22/2025	
Name and Location of Training Program: (ex: Internal Medicine, PEDS, etc.)		Level: (Circle One) Yr. of Training: I II III IV V VI VII RESIDENT.... OR... FELLOW	
Dates of Rotation at DH: 6/23/2021 - 6/22/2025	DH Dept. & DH Coordinator # Internal Medicine, Jennifer Weber 303-724-1788	RESIDENT UNIV. EMAIL ADDRESS:	
Resident NPI # (NATIONAL PROVIDER #)	Resident/Fellow Cell#	Resident/Fellow Pager#	

Account and Clinical Information Systems Access Request

Completion and submission of this request will provide you with the following:

- Account for Network Access
- Onbase (electronic record)
- Denver Health Intranet and Internet Access
- Radiology Imaging System (PACS)
- EPIC

Attestation and Delivery Instructions:

As a Denver Health Information Services account holder, I have reviewed and agree to comply with the Information Services Agreement. I understand that my authorization and use of Denver Health Internet access is permissive, routinely monitored and may be revoked at any time. I further understand that disciplinary and other actions up to and including discharge, may be taken for my violation of these responsibilities.

Please review and complete the top section of this form, initial and sign the Denver Health Information Services User Agreement attached, and sign and date below.

Signature:

____________________	____________________	__________
Requestor Name (please print)	Requestor Signature	Date

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ACKNOWLEDGMENT: NON-EMPLOYEE ORIENTATION AND TRAINING HANDBOOK

Please review the Non-Employee Orientation and Training Handbook before acknowledging the following and signing below:

☐ I understand that misconduct should be reported immediately to one of the following:
- A Denver Health Responsible Party
- Denver Health's Enterprise Compliance Services
- The ValuesLine (1.800.273.8452), or denverhealth.ethicspoint.com
- Denver Health Human Resources Department (for Professional Conduct issues)

And that reporting the misconduct may take the form of e-mail, US mail, phone, or office visit.

☐ I will provide services to Denver Health that comply with Denver Health's Code of Conduct, its values, professional conduct expectations and all policies, procedures and guidelines pertinent to the services I am providing. I understand that my compliance is a condition of my working relationship with Denver Health. I acknowledge I received information on key expectations of the Denver Health Code of Conduct (within the Orientation and Training Handbook). The complete Code of Conduct is located on The Pulse or on the Denver Health public website

☐ I am not aware of any existing issue that would pose a conflict of interest with my work here at Denver Health.
- If there is disagreement, Enterprise Compliance Services will require a Conflict of Interest Questionnaire to be completed and approved by the Chief Compliance Officer

Not applicable for Board of Directors members who must complete an annual disclosure form

☐ I further understand that in the performance of my services for Denver Health:
- I may have access to sensitive, privileged, confidential, or protected health information for patients, staff, or Denver Health in paper, electronic, or oral format whether personally identifiable or not.
- I understand that I am responsible for protecting the security of any records and the confidentiality of the information to which I have access, including my information systems username(s), password(s) and encryption requirements by Denver Health for laptops and mobile devices.
- I understand that breaching my obligation to protect the confidentiality and security of Denver Health information assets may result in liability, reporting to civil and criminal authorities and pressing of criminal charges that can lead to imprisonment and financial penalties.

☐ All Denver Health property in my possession must be returned, in good condition, at the end of my relationship with Denver Health. This includes, but is not limited to, any uniforms, keys, identification badges, pagers, cell phones, computers, computer access devices, company documents, etc. I understand that I shall be responsible for the cost to replace or repair Denver Health property lost or damaged by me.

☐ All non-employee Team Members are accountable to comply with the National Patient Safety Goals (NPSGs); I understand that my working relationship with Denver Health may be terminated if I am found to be non-compliant.

Today's date: ____________________ **Hospital/Institution:** University of Colorado

DH ID#: N/A **DH Department:** Internal Medicine

Print First and Last Name: ______________________________

Signature: ______________________________

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ACKNOWLEDGMENT: INFORMATION SYSTEMS USER ACCESS POLICY

The confidentiality of all patient health information is protected. The unauthorized disclosure of any information from the patient medical record or other computerized medical files may be punishable by law. **I UNDERSTAND THAT I AM RESPONSIBLE, BY LAW, FOR PROTECTING ALL PATIENTS' MEDICAL INFORMATION.** I understand that my obligation to protect this information does not end at the termination of my access to this facility's computer systems or at the end of my relationship with Denver Health.

___ (Initials)

I agree not to use any user ID to access, use, or disclose patient health information except as permitted by state and federal laws, including HIPAA. I may access, use, or disclose a patient's health information only within the scope of my services for treatment, payment, or health care operations or pursuant to a valid authorization. I understand that having access to Denver Health's systems does not give me the right to access a friend or family member's health information without going through the proper channels (requesting a copy of the medical record from the eHS Health Information Management Department). I understand that I am responsible for the confidential disposal of any health information that I print from the imaging system.

___ (Initials)

I understand that a violation of this agreement constitutes disregard of Denver Health policies and may result in termination of my relationship with Denver Health. Such termination will not prevent Denver Health from initiating a criminal investigation and seeking criminal prosecution when a law has been violated, or notifying appropriate medical licensing agencies when necessary.

___ (Initials)

As a non-employee who uses the Denver Health and Hospital Authority network and computing resources, I have reviewed, understand and agree to comply with the attached Information Systems User Access Policy.

______________________	Internal Medicine	______________
Print Name (Last, First, MI)	**Department**	**Date**

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