SUNY Downstate Medical Center

Office of Compliance & Audit Services

Compliance Training Enrollment Request Form

Form completed by:

- ◯ Authorized supervisor/Department Admin.
- ◯ New Employee Orientation Attendee*

*Date of Orientation:

Compliance Training Enrollment Information

First Name (Please PRINT)

Last Name

Department

2 Digit Month of Birth

2 Digit Day of Birth

Division (if applicable)

Dept. Administrator Name

Job Title / Role

Supervisor

Job Type (if applicable)

- ☐ Resident
- ☐ Faculty
- ☐ Volunteer
- ☐ Staff
- ☐ Vendor - Name:

NPI Number (if applicable)

License / Credential

Role Related Information

Employer

- ◯ State
- ◯ UPB
- ◯ RF

Location

- ◯ UHB
- ◯ BSB
- ◯ HSEB
- ◯ Off-site /Other

Please turn over to complete

Access (Please select all that apply)

- ☐ Individual has access to patient information
- ☐ Individual documents / reviews medical records

Individual performs registration/ billing functions for:

- ☐ Hospital (UHB)
- ☐ Physician Practice Plan (UPB)
- ☐ None of the above

Comments:

Signature of Department Administrator

I attest that the above listed individual has undergone proper 'on-boarding' including background check / exclusion screening / employee health screening (etc.) as applicable. I attest that the information above is accurate and can be relied upon to determine the appropriate training curriculum.

I understand that it will be the Department's responsibility to ensure that any training required is completed in a timely manner.

Signature / Name

Date

Signature of New Employee Orientation Attendee

By signing below I attest to receipt of the following materials: Compliance Web-based Training Instructions, HIPAA Pocket Guide, Internal Control, Compliance Line, DRA and Code of Conduct Brochures.

Signature