

POLICY AND DIRECTIONS FOR PROCESSING AN EXTERNAL ROTATOR

Please keep in mind that all packages for External Rotators must be submitted eight to ten weeks before the start of the rotation in order for the rotator to be credentialed and cleared to work. The following items for External Rotators must be sent to the GME Office to the attention of Michelle Henriquez and/ or Natalie Arrindell. The completed package may be hand delivered to room BSB 2-74, Faxed to 718-270-2408 or sent via email to mhenriquez@downstate.edu and/or Narrindell@downstate.edu.

* **Note: All External Rotators who will be working at KCHC must complete all procedures and policies at KCHC as well as SUNY. Items to be completed are listed in RED. SUNY Downstate Residency Coordinators should contact Janice Clarke at (718) 245-2027 for clarification.**

- **Affiliation Agreement:** There must be an affiliation agreement in place before any external rotator may rotate through SUNY Downstate. To confirm this has been completed please check with the department coordinator at SUNY and/or contact Syndi Webster at 718-270-2724.
- **Attestation Form:** Must be completely filled out and signed by the Program Directors of both institutions. It must reflect one rotation start date and one rotation end date. **(See Attached Form)**
- **Medical School Diploma:** Must submit a copy which has been stamped original seen along with a date and signature of the credentialing officer at the affiliated institution and it must be accompanied by a Certified USA Translation if applicable.
- **ECFMG:** Must submit a copy which has been stamped original seen along with a date and signature of the credentialing officer at the affiliated institution **(If Applicable).**
- **Questionnaire:** Must be completely filled out, must indicate the initial Program/Department entered as a PGY 1, must also be signed and dated and should be updated annually. **(See Attached Form).**
- **List of Procedures:** Procedures must be official from the affiliated Institution, must be current within the year and approved and dated by the Program Director. In the event the external rotator has no procedures on record an official letter from the Program Director must be submitted on letterhead signed and dated stating that he/she does not have procedures with justification.

- **Employment Eligibility:** The GME Office must view the **Original** Employment Eligibility/Proof Of Citizenship documents. **(example: USA Passport, USA Drivers License, J-1 DS2019 and Passport or H-1 and Passport etc...)**
- **Social Security Card** The GME Office must view the **Original** Social Security Card for All incoming External Rotators
- **Medical Regulatory Form & Health Clearance:** The Rotator Medical Regulatory Requirements Form must be completed and returned. **Once the form has been received, the resident must be given the form and sent to EHS in order to obtain a Final Clearance Form. Only when the Final Clearance Form is received is the resident cleared for Health Clearance.** A copy of the Rotator Medical Regulatory Requirement Form and the Final Clearance Form must be part of the completed rotators. **(See Attached Form)**
- **BCLS:** Must submit a current BCLS and/or ACLS certification.
- **Background Check:** This may be a signed, standard letter on letterhead from the affiliated Institution stating that rotator has done a background check and there were no discrepancies found and/or the actual background check itself. **In the event that the institution does not have either, it will be the external rotators responsibility to obtain a background check at his/her own expense.**
- **Federal/State (i.e. Medicare/Medicaid) Exclusion Check:** Done by Human Resources at SUNY Downstate.
- **SUNY HIPPA:** The User Login ID is issued by the Office of Corporate Compliance and **NPI Numbers are needed in order to obtain a User Login ID (SEE NPI NUMBERS)**. The SUNY Downstate Residency Coordinators must complete the enrollment request form located at <http://www.downstate.edu/compliance/documents/ComplianceTrainingEnrollmentRequestForm.4.0.pdf> and email it to the attention of Compliance at Compliance@Downstate.edu, **who will in turn email them the User Login ID for the rotator.** All External Rotators must log in to www.downstate.edu and click on the **Compliance & HIPPA Training** and complete the following Components of HIPPA before they are cleared to begin their rotation at SUNY.
 1. **HIPPA Training**
 2. **Fraud Compliance**
 3. **Documentation Improvement****Print and present all 3 certifications to the GME Office.**

- **KCHC HIPPA:** Only applies to External Rotators who will be rotating at Kings County Hospital. External Rotators will go to KCHC House Staff office (T-Bldg. on the 3rd floor room # 316) after fulfilling all credentialing requirements at SUNY.
- **Hospital Orientation:** Instructions for completion are as follows.

 1. Go to <http://www.downstate.edu/icl/nro>
 2. Select the appropriate AME to take (**Licensed Professional AME**)
 3. Review the PowerPoint slides.
 4. Click on the web link to proceed to the Post Test.
 5. Provide Name, Title, Department and Email Address.
 6. Complete post-test
 7. Click on '**Grade Your Test**' located at the bottom of the form. Retake post-test, if warranted.
 8. **Print and present to GME Office.**
- **NPI Numbers:** The NPI (National Provider Identification Number) is needed by SUNY Downstate Residency Coordinators in order to request a User Login ID from the Office of Corporate Compliance in order for External Rotators to complete their HIPPA Training online. (See **SUNY HPPA**) The NPI number must also be submitted to the GME Office along with the External Rotators completed package. (See **Email Attachment**)
- **Rotator to Downstate Form:** Must be completed by the External Rotator and the Program Director and it must [indicate the Department/Program the external rotator is coming from as well as the Department/Programs ACGME Number.](#) (See **Attached Form**)
- **CV Addendum:** Must be completed in its entirety (See **Attached Form**)
- **Emergency Contact Form:** **This form will be given to the External Rotator for completion when they arrive to meet with Michelle Henriquez of the GME Office for clearance and submitted to DHR.**
- **Fair Act Form** **This form will be given to the External Rotator for completion when they arrive to meet with Michelle Henriquez of the GME Office for clearance and submitted to DHR.**
- **Pre Employment Data Form** **This form will be given to the External Rotator for completion when they arrive to meet with Michelle Henriquez of the GME Office for clearance and submitted to DHR.**

- **Health Bridge Training** For External Rotators, Coordinators should contact Health Bridge at healthbridge@downstate.edu and call the helpdesk at ext 4357 to request login information in order for them to complete the online training before their start date at SUNY Downstate. **They can follow the training instructions enclosed on the last page in this package.**
- * **Note:** External Rotator Packages must be submitted to the GME Office six weeks prior to their start date. As of July 1, 2014, this policy will be strictly enforced and any external rotator whose paperwork has not been submitted 6 weeks prior to start date will be unable to begin rotating at DMC. This is to ensure that rotators are processed through state DHR for Federal/State (i.e. Medicaid /Medicare) exclusion check purposes. External Rotators must present themselves to the GME Office at least two weeks prior to their start date in order to obtain final clearance.
- No External Rotator will be cleared to work without a completed credentialing package and therefore should not be working on the floors. **There are no exceptions.**

Prepared by Michelle Henriquez
Assistant Director, GME
October 13, 2010
Revised 12/19/14

Updated by Natalie Arrindell
Administrator, GME
September 18, 2018

SUBJECT: VISITING/ROTATING RESIDENTS (“External Rotators”)

1. Purpose

The policy will provide guidelines for the appointment of Visiting/Rotating Residents (“External Rotators”) at SUNY Downstate Medical Center (“SUNY-Downstate”).

2. Policy

In support of its mission, SUNY Downstate will provide External Rotators with clinical training and experiences in conformance with the applicable Medical Staff Bylaws – Rules and Regulations, the GME Resident’s Handbook, the SUNY Downstate – Policies and Procedures, and the External Rotator Agreement (“Agreement”).

NOTE; External Rotators will be allowed to participate in patient care activities only if there is a signed Agreement on file in the GME Office

3. Definitions

Visiting/Rotating Resident (“External Rotator”): a resident currently enrolled in training program at another institution.

Parent Residency Program (PRP): the Visiting/Rotating resident’s current program.

Rotation: refers to approved time spent at UHB for clinical experience.

External Rotator Agreement: establishes the formal and continuing relationship between SUNY-Downstate and the External Rotator, during his/her participation in the clinical training program.

4. Responsibilities

It is the responsibility of the following administrative offices to ensure compliance with this policy:

- Departmental Chairperson
- Office of the Chief Medical Officer
- Office of the Chief Executive Officer
- Office of the Dean – College of Medicine
- Department of Human Resources
- Employee Health Services
- Identification Card Office
- Office of Corporate Compliance
- Office of Planning
- Office of Graduate Medical Education
- Office of University Counsel

5. Procedure/Guidelines:

A. Departmental Chairperson/Department Head

The Departmental Chairperson or designee recommends the prospective External Rotator for an unpaid appointment as a Clinical Assistant Instructor (HS) at SUNY Downstate and forwards the following documents to the Office of Graduate Medical Education (GME) for review:

- HAF Form (Initial and Notification of house staff change)
- Evidence of Background Check
- Evidence of Rotator Regulatory Requirement
- Evidence of Malpractice Insurance
- Evidence of Hospital Orientation on-line
- Evidence HIPAA/Professional Compliance Training Programs on-line
- Proof of US citizenship, permanent resident status, or other authorized status
- Evidence of Educational Commission for Foreign Medical Graduates (ECFMG)
- Medical School Diploma
- List of privileges from rotator parent hospital signed by Program Director

Questions concerning the on-line HIPAA Compliance Training Program should be directed to Zhanna Kelley at extension 6734. Questions concerning the on-line Hospital Orientation Program should be directed to Patrick Sandoval at extension 8112.

Note: The availability and scheduling of clinical rotations by External Rotators are at the discretion of the individual clinical department.

B. Graduate Medical Office (GME)

Upon receipt of the prospective External Rotator's appointment package, GME will facilitate the following pre-rotation reviews:

1) Background Checks

Evidence of satisfactory completion of a criminal background check from employer/ parent hospital. In the event that the requested information is unobtainable or adverse, DHR, in collaboration with GME, will convene a Committee, including the sponsoring department, to determine whether or not to confirm the unpaid appointment.

All information obtained will be maintained in a confidential manner.

2) Medical Clearance

Evidence of Rotator Regulatory Requirements from Employer would be given to UHB Employee Health Services. (Note: Upon written request from SUNY HSCB, the Sponsor/ parent hospital shall provide a copy of original file to the employee health division of said training site before the close of the next business day provided that such request is in connection to medical care for the resident or an on-going investigation or audit.)

3) Immigration Review (I-9 Employment Eligibility)

In accordance with the Immigration Reform and Control Act of 1996 (IRCA), GME will schedule an appointment for the prospective External Rotator to present him/herself with acceptable original documentation that

substantiate his/her identity and authorization to work in the United States in conformance with the United States Citizenship and Immigration Services (USCIS) guidelines.

4) Identification Card

Upon receipt of all appropriate signatures, GME will issue a notice to the External Rotator so that he/she may obtain an employee ID cards from the I.D. card Office. GME will also be responsible for maintaining the credentials files. (DHR will be responsible for maintaining the official personnel files.)

GME will also send DHR a copy of the original HAF form along with copies of the checklist items listed below:

- Background checks
- I-9 with Employment Eligibility
- Pre-Employment Data Sheet
- Fair Credit Reporting Act Form
- Emergency Contact Form
- Health Clearance

***Initial Sign In sheets distributed to departments by DHR must be completed by all External Rotators in their respective departments on the first day of rotation and submitted to DHR by departments**

The original HAF form will be noted by GME to indicate completion of orientation, health clearance, and any other missing documents will be submitted to DHR within four (4) days of completion of orientation.

It should be noted that the clinical department should notify the GME Office preferably two (2) months in advance of the prospective Visiting Resident's rotation.

C. Department of Human Resources (DHR)

1) Office of Inspector General (OIG) Review

DHR will conduct an OIG review to ensure that the prospective External Rotator does not have any relevant actions against him/her that would make him/her unsuitable or ineligible for rotation at SUNY-Downstate.

In the event that the requested information is unobtainable or adverse, DHR, in collaboration with GME, will convene a Committee, including the sponsoring department, to determine whether or not to confirm the unpaid appointment.

D. External Rotator

External Rotators will be responsible for abiding by the policies, rules, regulations, and bylaws of SUNY-Downstate, as delineated in the UHB Medical Staff Bylaws – Rules and Regulations, the GME Resident's Handbook, the SUNY Downstate – Policies and Procedures, and the External Rotator Agreement.

CHECKLIST FOR EXTERNAL ROTATORS

Name: _____ Department Rotating To: _____

PGY Level: _____ Degree: _____

Parent Hospital: _____ Dates of Rotation: _____ to _____

Initial Rotation
 Returning Rotator
 Rotating to KCHC

DOCUMENTS	YES/NO	COMMENTS
Affiliation Agreement (confirm with departments and Syndi Webster)		
Attestation Form (Must have both institutional signatures)		
Medical School Diploma (with translation, if applicable)		
ECFMG certificate (if applicable)		
Questionnaire (standard residency questionnaire)		
List of Privileges (must be dated within the year and have signature)		
Employment Eligibility Proof of Citizenship (must be ORIGINAL)		
Social Security Card (must be ORIGINAL)		
Health Clearance/ Medical Mandatory Requirements (with current evidence of Flu Shot) (must have ORIGINAL signatures)		
BCLS/ACLS certification (mandatory as of January 1, 2010)		
Evidence of Criminal Background Check (Letter from current Institution)		
Federal/State (i.e. Medicare/Medicaid) Exclusion Check (mandatory as of July 1, 2014)		
Evidence of SUNY HIPAA Online (Fraud, HIPPA, Documentation Improvement)		
Evidence of Hospital Orientation On Line (Print out the grades)		
NPI# (National Provider Identification Number)		
Rotator to Downstate Form (Must complete the bottom also)		
CV Addendum Form (Must complete in its entirety)		
Emergency Contact/Fair Act/Pre Employment Data Forms (Must complete in its entirety)		

Cleared By: _____ Date Cleared: _____



- These documents have been copied and given to the Rotator to deliver to KCHC (T-Bldg, 3rd Fl. Rm 316)
- Documents have been sent directly to KCHC (scanned & e-mailed and/or placed in KCHC's bin)
- Document copies have been hand delivered and /or scanned & e-mailed to Human Resources.
- Documents have been entered into New Innovations.

**ATTESTATION OF CREDENTIALING AND MALPRACTICE COVERAGE
FOR INDIVIDUAL ROTATORS TO
SUNY Downstate Medical Center & Kings County Hospital Center**

TO WHOM IT MAY CONCERN:

This is to confirm the agreement between _____ and State University of New York
(Parent Hospital)

Downstate Medical Center and Kings County Hospital Center to allow your resident to rotate through our institution.

Dr. _____ PGY _____ will be doing the following rotation in

_____ From _____ To _____. During this period
(Specialty) (Date, Mo/Day/Yr) (Date, Mo/Day/Yr)

Dr. _____ will be paid by _____ and will
(Parent Hospital)

receive all benefits from said hospital including malpractice insurance. It is also understood that all residents from your institution rotating through the SUNY Downstate Medical Center & KCHC residency program are properly credentialed graduates from an approved Medical school with ECFMG certification (if applicable). By signing below, it is understood that the above mentioned doctor has been credentialed, holds a current list of procedures, and has received a health clearance within one year of the specified rotation date and that all supporting documents, including the medical records, will be available to us upon request. All required documents should be forwarded to the GME office at least six weeks in advance and residents should be aware that they must report to Graduate Medical Education Office on the first weekday of their rotation to complete all the necessary paperwork (**please refer to the SUNY GME rotation policy & procedure attached**). Thank you for your cooperation.

Print Name of Dept. Program Director/Designee
(Parent Hospital)

Signature of Dept. Program Director/Designee
(Parent Hospital)

Print Name of Dept. Program Director/Designee
(SUNY Downstate)

Signature of Dept. Program Director/Designee
(SUNY Downstate)

Rotator Medical Regulatory Requirements

TO: _____
(Name of Sponsoring Institution)

REF: _____
(Name of Rotator) (last four digits of Social Security number)

Please attest that the following documentation for the above-named individual is on file with your institution.

1. An initial Health Assessment granting fitness for duty in a health care facility, including evidence of current annual Flu Shot.
2. Evidence of an Annual (or initial) Health Assessment within the past twelve (12) months certifying no illness or conditions found that would jeopardize or impair ability to work.
3. Record of immunity or full vaccination to Rubella
4. Record of immunity or full vaccination to Rubeola
5. Varicella titer positive or proof of two (2) Varicella vaccines
6. Record of immunity or full vaccination to mumps (2doses)
7. Record of Mantoux PPD skin test for tuberculosis or Quantiferon – Gold blood test prior to placement and at least annually thereafter, if negative. IF positive, appropriate clinical follow – up (chest x-ray) has been documented and clearance established by private physician or Department of Health.
8. For persons with a predictable possible exposure to blood or infectious body fluids, proof of either a) immunity to Hepatitis B or b) that full Hepatitis B vaccination has been given or c) if declined, proof of declination.
9. OSHA Respiratory Training and Medical Clearance for Fit - Testing. (N-95 particulate respirator)
10. Drug Screening

For The Institution Named Above (both signatures required)

❖ Administrator responsible for Occupational Health for the above sponsoring institution or employer:

Date **Print Name** **Signature**

❖ Physician or Director of Occupational Health for the above sponsoring institution or employer:

Date **Print Name** **Signature**

PLEASE FORWARD COMPLETED FORM TO SUNY DOWNSTATE MEDICAL CENTER, GME OFFICE, 450 CLARKSON AVENUE, BOX 1229, BSB ROOM 2-74 BROOKLYN, N.Y. 11203, FAX # 718-270-2408, AT LEAST 6 WEEKS PRIOR TO THE START OF YOUR ROTATION. THESE FORM MUST BE COMPLETED AND SUBMITTED ANNUALLY, IF ONGOING.

ROTATOR to Downstate GME Programs

**Completed form must be submitted to the House Staff Affairs/
GME Office for EVERY External Rotator for EVERY Rotation.**

House Staff (Rotator) Name: _____

Name of Hospital Rotating From: _____

City and State: _____

Name of Department/Program Rotating From: _____

Program ACGME Number (if new affiliate): _____

Dates of Elective/Rotation:

FROM: _____ TO: _____

Department Rotating Through: _____

SUNY Extension and Contact: _____

This box to be filled out by SUNY Program rotator going to.

Rotating Service	% at SUNY	% at KCHC	% at Other , Indicate Where

This box to be filled out by Program Rotator is coming from

IF RETURNING TO HOME INSTITUTION FOR CLINIC , DIDACTIC or CALL, HOME INSTITUTION MUST REPORT PERCENT OF TIME OR WHAT DATES HOME INSTIUTION WILL BE CLAIMING FOR IRIS CMS		
Returning to Home Institution during rotation - YES or NO	If YES, % of time Home Institution will claim during From /To dates <i>(e.g. 20% for 1 clinic day clinic a week)</i>	OR if YES, What dates Home Institution will claim

Program Director Signature and DATE

(Program Director at SUNY Downstate) _____

Rotator Signature and DATE: _____

EMERGENCY REFERENCE CARD

NAME: _____

TITLE: CLINICAL ASSISTANT INSTRUCTOR (HS)

DEPT: _____

- NOTIFY IN CASE OF EMERGENCY

NAME: _____ ADDRESS: _____

PHONE#: _____ RELATIONSHIP: _____

* Person should be able to be contacted during working hours, Alternate name is also recommended.

SUNY DOWNSTATE MEDICAL CENTER

FAIR CREDIT REPORTING ACT CONSUMER DISCLOSURE AND AUTHORIZATION

Facts You Need to Know:

In connection with your application for employment and/or appointment to the medical Staff with SUNY Downstate Medical Center (hereafter referred to as the “Company”), the Company may obtain a consumer report on you, as defined in the federal Fair Credit Reporting Act, 15 U.S.C. 1681 et seq. The consumer report will provide verification of the highest degree earned, verification of your most recent employment, and records of any criminal convictions.

The Company may not obtain any consumer report on you for employment purposes and/or medical staff privileges without your written consent. Also, the Company may not obtain medical information about you without your express consent to the release of medical information. Consent to the release of medical information is not covered by the authorization contained in this document.

State-specific Information:

- California – If you are a California resident, in addition to this disclosure/authorization, you must review and complete the “Disclosure and Acknowledgement Concerning Consumer Credit Report Obtained for Employment Purposes Pursuant to California Law.
- Minnesota – If you are a Minnesota resident, you have a right to obtain a copy of the consumer report by checking this box.
- Oklahoma – If you are an Oklahoma resident, you have a right to obtain a copy of the consumer report by checking this box.

Consent and General Authorization to Obtain Consumer Report

I hereby authorize the Company, now or at any time while I am employed by the Company and/or hold appointment to the Medical Staff, to obtain a consumer report on me. This authorization does not authorize the release of medical information.

Federal law prohibits discrimination in employment and/or appointment to the Medical Staff on the basis of race, color, sex, national origin, religion, age, equal pay or disability. Additionally, New York State law prohibits discrimination in employment and/or appointment to the Medical Staff on the basis of creed, sexual orientation, military status or marital status.

Applicant Signature

Today’s Date

Applicant’s Name Printed



SUNY DOWNSTATE MEDICAL CENTER PRE-APPOINTMENT DATA FORM

Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Widow <input type="checkbox"/> Divorced		Budget Title: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security #: _____	Date of Birth: _____
Salutation: <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.		Local Title: _____
Name (Last, First, MI): _____		Department: _____
Home Address: _____		Location: <input type="checkbox"/> BSB <input type="checkbox"/> UHB
Home Phone #: _____ Cell Phone #: _____		<input type="checkbox"/> Educ. <input type="checkbox"/> 440 Lenox Rd.
		<input type="checkbox"/> Other
		Room #: _____ Box #: _____
		Campus Phone #: _____

Are you a U.S. Citizen? Yes No | Country of Citizen: _____ Visa Type: _____ Expiration Date: _____

EDUCATION

Highest Education Level: _____ Year Graduated: _____ Highest Degree _____
 Degree Discipline: _____ Degree Program/major: _____
 Name of College/University: _____
 Degree Country: _____ College/University State: _____ College/University City: _____

LICENSURE/CERTIFICATE/PERMIT

License No. _____ Professional Discipline: _____ Date Issued: _____ Exp. Date: _____
 Certificate No. _____ Professional Discipline: _____ Date Issued: _____ Exp. Date: _____
 Permit No. _____ Professional Discipline: _____ Date Issued: _____ Exp. Date: _____

ADDITIONAL INFORMATION

Military Service: From: _____ To: _____ Disabled Veteran: Yes No Selective Service Status: _____

Prior State Service? <input type="checkbox"/> Yes <input type="checkbox"/> No Agency: _____ Title: _____ Dates: From: _____ To: _____	Prior Research Foundation Service? <input type="checkbox"/> Yes <input type="checkbox"/> No Agency: _____ Title: _____ Dates: From: _____ To: _____
--	--

There are occasions when D.M.C is in need of translators, will you volunteer? Yes No
 Language(s) _____ Check all that apply
 Speak Read Write
 Speak Read Write

Do you sign for the deaf? Yes No
 If yes, will you Volunteer? Yes No

Department of Health – O.S.H.A – Exposure Determination
 Will your duties/responsibilities involve exposure to human tissue, blood, body fluids and/or infectious material (Y/N) _____
 If yes, where? (Check all appropriate boxes) University Hospital DMC Non-Hospital Other

Do you currently receive a pension for the New York State or the Municipal System? Yes No

Have you ever been excluded from participation in the Medicare Program? Yes No
 If yes, please provide dates of exclusion and reinstatement.

Have you ever, or are you currently involved in any form of disciplinary/investigative process before? Yes No
 any State licensing body or any accrediting body? If yes, provide details

Except for minor traffic violations, have you ever been convicted of any violation of the law? Yes No
 If yes, please provide date, charge and disposition

Privacy Act Statement

In order to ensure SUNY Downstate Medical Center’s compliance with Federal Register Notice of November 28, 2005, mandating employers to obtain employee’s race and ethnic information via self-identification under new race and ethnic categories, please answer both Questions 1 and 2.

Please note that information disclosed is completely confidential, and will be used for EEO reporting purposes only.

Question 1: Are you Hispanic or Latino? (A Person of Cuban, Mexican, Puerto Rican, Central or South America, or other Spanish Culture or origin, regardless of Nationality) Yes (If Yes, Select Hispanic/Latino country of origin from list below)

No

HISPANIC/LATINO COUNTRY GROUPS

CENTRAL AMERICAN	SOUTH AMERICAN	OTHER HISPANIC OR LATINO
<input type="checkbox"/> Costa Rican <input type="checkbox"/> Guatemalan <input type="checkbox"/> Honduran <input type="checkbox"/> Nicaraguan <input type="checkbox"/> Panamanian <input type="checkbox"/> Salvadoran <input type="checkbox"/> Other Central American	<input type="checkbox"/> Argentinean <input type="checkbox"/> Bolivian <input type="checkbox"/> Chilean <input type="checkbox"/> Colombian <input type="checkbox"/> Ecuadorian <input type="checkbox"/> Paraguayan <input type="checkbox"/> Uruguayan <input type="checkbox"/> Venezuelan <input type="checkbox"/> Other South American	<input type="checkbox"/> Cuban <input type="checkbox"/> Spanish <input type="checkbox"/> All other Spanish or Latino <hr/>

Question 2: What race/races do you consider yourself to be? Please check the racial category/categories below, with which you most closely identify.

RACIAL CATEGORIES (Check as many as apply)	DEFNITION OF CATEGORY
<input type="checkbox"/> American Indian or Alaska Native (Non-Hispanic/Latino only)	All persons having origins in any of the original peoples of North American and who maintain cultural identification through tribal affiliation or community recognition.
<input type="checkbox"/> Asian (Non-Hispanic/Latino)	All persons having origins in any of the original peoples of the Far East, Southeast, Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippines Islands, Thailand, and Vietnam.
<input type="checkbox"/> Black or African American (Non-Hispanic/Latino)	All persons having origins in any of the Black racial groups of Africa
<input type="checkbox"/> Hispanic of any race	All persons of Mexican, Cuban, Puerto Rican, Central or South America, or other Spanish culture or origin.
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander (Non-Hispanic/Latino)	All persons having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands
<input type="checkbox"/> White (Non-Hispanic/Latino)	All persons having origins in any of the original peoples of Europe, North Africa, or the Middles East
<input type="checkbox"/> Multi-Racial (Non-Hispanic/Latino)	All persons having origins from two or more races.

APPLICANT’S ACKNOWLEDGEMENT & CERTIFICATION

I authorize DMC to investigate all matters contained in this document, including the conduct of a criminal background check and verification of my education and work experience, and agree that any misleading or false statement be sufficient cause for immediate cancelation of my appointment and/or dismissal from employment. I understand that my appointment/employment is dependent upon satisfactory completion of a physical examination, (including alcohol and drug screening), proof of eligibility to work in the United States, proof of identity and verification of references, I agree, If appointed/employed, to abide by all Medical Center rules and regulations.

I hereby affirm that this application, resume/curriculum vitae, cover letter and any and all documents submitted by me in connection with my application for employment contain no willful misrepresentation and that the information given by me is true and complete. I understand that any false statements or misleading omissions made by me in connection with my application, or in responding to any requests for information, can be sufficient grounds for my rejection as a candidate for employment or for my immediate termination and/or referral for criminal prosecution. I authorize persons, schools, my current employer (if applicable), and previous employers and organizations named in this application (and accompanying documents, if any) to provide any relevant information that may be needed to arrive at an employment decision.

I certify that the information that I have provided is complete and accurate.

Applicant’s Signature	Date
------------------------------	-------------



Blackboard & Healthbridge Modules Access

- A. To access Blackboard, go to www.downstate.edu
- B. Click 'myDownstate'



- C. Click 'Blackboard'





Blackboard & Healthbridge Modules Access

D. Log into Blackboard using your netID username and password.

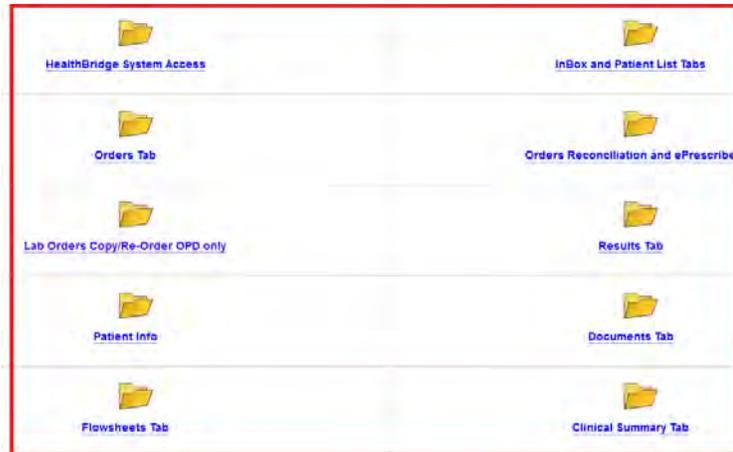
E. In the 'My Courses' section, click Hospital Training: Healthbridge, Cerner and Other Systems

F. Click Healthbridge Training



Blackboard & Healthbridge Modules Access

G. Complete all of the Healthbridge Training Modules



H. Complete the 'Healthbridge Credentialing Exam (v1)'



- I. Once the exam is passed with a score of 70% or higher, please call the Healthbridge Service desk at 718-270-4357 option 1 to receive your Healthbridge username and password.

******Note: Please wait until you have obtained your Downstate ID card before calling the Healthbridge Helpdesk. You MUST have your Downstate ID card available as the UID # is used for validation purposes.**