Clinical Rotation Checklist

- ☐ Resident Name and Degree _____
- ☐ Copy of Medical Diploma _____
- ☐ Current Program Specialty _____
- ☐ Program Coordinator name _____
  and contact number/email _____
- ☐ MCG/AU Rotation Dates/Depart

_____

_____

- ☐ Augusta University Prog. Coordinator name/number and email _____
- ☐ Criminal Background Form _____
- ☐ GME Forms _____
- ☐ Employee Health MEMORANDUM (please attach) _____
- ☐ NPI Number _____
- ☐ GA Medical License # _____
- ☐ Date of Birth _____
- ☐ Resident Phone number _____
- ☐ Resident E-mail address _____

MCG/AU GME Office use only

e-Par submitted _____

NET ID Issued _____

Badge form send to JAGCARD_____

Banner # _____

Paperwork submitted to HR _____

Computer training scheduled_____

SA Request _____

HQ# _____

NET ID and email instructions sent to resident _____

AUGUSTA
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House Staff Request for Electronic Signature Privileges

I the undersigned desire to authenticate reports of my patients through the use of electronic signature applications approved by Wellstar MCG Health (WMCG). I hereby acknowledge that I received instructions in the proper use and consequences of any misuse of my electronic signature. I understand that all results that are finalized with my security code will be treated as written signature with all the ethical, business and legal implications. All electronically signed documents placed in the patient medical record (including paper-based records) are deemed legitimate chart documents.

I agree not to share my password with any other individual or allow any other individual to use the system once I have accessed it. I understand that I may have my password changed at any time by the administrator.

If I have reason to believe that the confidentiality and security of my password have been compromised, I will report this information to the system administrator or my supervisor immediately so that the suspect code can be deleted and a new code assigned to me.
I understand that my electronic signature privileges will be withdrawn if I allow any other individual to utilize my signature code/password.

I understand that any misuse of my signature code/password or breach of security or confidentiality may constitute a violation of Federal or state laws or WMCG policies. Such a violation may result in disciplinary action, including formal reprimand, suspension of privileges, termination of employment, civil prosecution or federal criminal prosecution.

Name (First, Middle, Last Name)

Medical College of Georgia Training Program

Signature

Date

OFFICE OF GRADUATE MEDICAL EDUCATION

Mailing Address:
1459 Laney Walker Blvd., AE 3042
Augusta, Georgia 30912

T (706) 721-7005

F (706) 446-0305

augusta.edu

AUGUSTA
UNIVERSITY

Augusta University
Pre-employment Drug Screen Request

This form must be completed, signed, dated and returned with your packet as a part of your application for rotation.

My signature below indicates my consent and authorization to have my urine screened for illegal drugs as a precondition of my rotation through Wellstar MCG Health (WMCG) affiliated with the Medical College of Georgia at Augusta University. I hereby consent to have the results of my urine drug screening reported to the appropriate personnel at Augusta University. I understand that in the event that I test positive for the illegal drugs, I will be ineligible for a rotation at WMCG and affiliated sites.

(Please print clearly)

Print Name (First, Middle, Last Name), Jr./Sr., etc.

Medical College of Georgia Training Program

Current Address:

Social Security Number

Signature **Date**

OFFICE OF GRADUATE MEDICAL EDUCATION

Mailing Address:
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RELEASE OF INFORMATION FORM

I hereby authorize (name of Medical School) _____to release any and all information requested by The Medical College of Georgia at Augusta University in order for them to verify my professional competence, ethics, character, credentials, academic record and other qualifications for a House Officer appointment. In doing so, I hereby waive any rights of confidentiality in these records, including these granted by the Family Education Rights and Privacy Act, and I release and hold harmless anyone making good faith use of such information in accordance with this release.

_____

Medical College of Georgia Training Program

_____

Print/Type Name (First, Middle, Last Name), Jr./Sr., etc.

_____

Social Security Number

_____ _____

Signature **Date**

OFFICE OF GRADUATE MEDICAL EDUCATION

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AUGUSTA UNIVERSITY

Background Request Form

This form should be used by departments to provide Human Resources required information for a Criminal Background review be initiated for a candidate. Please notify the candidate to be on the lookout for an email from Accurate to complete their background.

Please provide the following information:

First Name: _____

Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Phone Number: _____

Position Number: ___(GME Use Only)_____

Title: _____

Department: _____

Estimated Hire/Start Date: _____

Department Contact: _____

AUGUSTA UNIVERSITY

Employee Health Requirements

Please check off what will be included in the packet to the GME coordinator.

For non-Wellstar & non DDEAMC

- ☐ M3 Mask Fitting (anytime but must be M3)
- ☐ Colorblind testing (anytime)
- ☐ UDS, at least 10 panel (within 90 days of rotation)
- ☐ Titers or proof of vaccination for Hepatitis B, MMR, and varicella
- ☐ Flu vaccination (depending on time of year)
- ☐ TB questionnaire and IGRA test results
- ☐ (for past positive IGRA, cleared CXR if required with TB questionnaire) If treated for TB, then proof of treatment)
- ☐ Proof of previous covid vaccinations

For DDEAMC

- ☐ M3 Mask Fitting (anytime but must be M3)
- ☐ Colorblind testing (anytime)
- ☐ Memorandum of understanding for UDS
- ☐ Titers or proof of vaccination for Hepatitis B, MMR, and varicella
- ☐ Flu vaccination (depending on time of year)
- ☐ TB questionnaire and IGRA test results
  (for past positive IGRA, cleared CXR if required with TB questionnaire) If treated for TB, then proof of treatment)
- ☐ Proof of previous covid vaccinations

For Wellstar

No Employee Health Requirements

Please be advised that the Employee Health requirements must be completed at Wellstar MCG Health (WMCG). If you require an appointment to fulfill these requirements, please let me know. Additionally, please note that Augusta University/The Medical College of Georgia will not provide reimbursement for any costs incurred if these requirements are completed outside of WMCG.