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 _____
  _____
  _____
- ☐ Criminal Background Form _____
- ☐ GME Forms _____
- ☐ Occupational Health SVC-PPD Clearance _____
- ☐ NPI Number _____
- ☐ GA Medical License # or N/A _____
- ☐ Date of Birth _____
- ☐ Resident Phone number _____
- ☐ Resident E-mail address _____

AU GME Office use only

e-Par submitted_____ Paperwork submitted to HR_____

NET ID Issued_____ Institutional DEA_____

Badge form send to JAGCARD_____ Computer training scheduled_____

ASEPSIS_____

NET ID and email instructions sent to resident_____

AUGUSTA
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House Officer Request for Electronic Signature Privileges

I the undersigned, desire to authenticate reports of my patients through the use of electronic signature applications approved by AU Health. 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I understand that my electronic signature privileges will be withdrawn if I allow any other individual to utilize my signature code/password.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 AU Health policies. Such a violation may result in disciplinary action, including formal reprimand, suspension of privileges, termination of employment, civil prosecution or federal criminal prosecution.

_____ _____

Print 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) 446-3546

augusta.edu

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Augusta University
Pre-employment Drug Screen Request

This form must be completed, signed, dated and returned with your new resident packet as a part of your application for employment. Upon an offer of employment, information regarding pre-employment drug screening procedures for Housestaff entering training programs at the Medical College of Georgia at Augusta University will be provided prior to the start date.

My signature below indicates my consent and authorization to have my urine screened for illegal drugs as a precondition of my employment by Augusta University and as required by Georgia Law. 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 employment at Augusta University.

(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

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AUGUSTA
UNIVERSITY

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 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: _____ Title: _____

Department ID: _____ Department: _____

College/Admin Unit: _____

Location: the city and state the position will work: _____

Estimated Hire/Start Date: _____

Department Contact: _____