ORIENTATION CHECKLIST FORM

PLEASE PRINT LEGIBLY

DATE:_____

NAME:_____ SERVICE:_____
Last Name First Name Middle Initial Specialty where you will be working

SCHOOL AFFILIATION:_____ FULL SS#_____

Rotation dates: From:_____ To: _____
Month/Day/Year Month/Day/Year

E-Mail Address:_____ **NPI #** _____
Medical Residents/Podiatry Residents/Optometry Residents

Telephone:_____ Cell#/Pager#:_____
(Area Code) (Area Code)

Emergency Contact:_____ _____
(Name) Telephone Number (including Area Code)

Student Year or PGY Level:_____ **Current Degree:** MD ❑ DO ❑ OD ❑ DPM ❑ **Male❑ -or- Female❑**

MANDATORY TRAINING **CHECKLIST**
1. General Employee Privacy Awareness **Certificate/transcript attached (printed from Internet)**
2. VA Information Security Awareness **Certificate/transcript attached (printed from Internet)**
The following topics are discussed in Resident/Student Handbook
1. Environment of Care (Fire and Safety)
2. Infection Control
3. Risk Management/Patient Safety
4. Cultural Diversity/LEP/Sexual Harassment & EEO Complaint Process/ No Fear Act
5. Ethical Conduct
6. Mission-Vision-Values-Goals
7. Patient Rights
8. Patient Abuse
9. Mental Health Environment of Care-Reducing Patient Suicide Risk
10. Compliance
11. Resident Supervision- supervising Practitioner Responsibilities

I acknowledge that I have received a copy of the Resident/Student Orientation Handbook at the beginning of my clinical rotation. I have reviewed and fully understand the information provided in this handbook including the mandatory training listed above.

_____ _____
Signature **Date**