Graduate Medical Education Health Professions Trainee Application Package

The Associate Chief of Staff for Education Office is available to assist GME trainees and Medical Staff Mondays through Fridays, 8 a.m.– 4:30 p.m. For assistance please call the VA GME Office at 504-412-3700 Ext: 8088. Our office Fax number is 504-566-8415. To coordinate for a fingerprinting appointment at the New Orleans, LA VA or nearest VA location please email a request to vhanolgmefingerprinting@va.gov

VA Office location:
1515 Poydras Street, 7th floor Room 736
New Orleans, LA 70112

VA New Application Package Checklist

Please return the documents listed below to your Residency Coordinator:

- ☐ Signed Without Compensation Appointment Letter
- ☐ VA Application for Health Professions Trainee, VA form 10-2856d
- ☐ Signed Medico-Legal Responsibilites of House Staff
- ☐ VA form 0711, Personal Identification Verification Card form
- ☐ Appointment Affidavit Standard Form 61, *can be signed by a notary or signed by a VA personnel official*
- ☐ Online TMS training certificate *see attached guide on how to create an account*
- ☐ Signature form of Numbered Memorandum 00-4, Protection of Patients From Abuse

DEPARTMENT OF VETERANS AFFAIRS
Southeast Louisiana Veterans Health Care System
P. O. Box 61011
New Orleans LA 70161-1011

In Reply Refer To: 629/002C

APPOINTMENT LETTER FOR TRAINEES PAID
THROUGH A DISBURSEMENT AGREEMENT

3/1/2016

Dear VA Health Professions Trainee:

Welcome to the Department of Veterans Affairs (VA) and the Southeast Louisiana Veterans Health Care System (SLVHCS). You will be given a ***without compensation appointment*** at our facility as a Medical Resident/Fellow between July 1, 2016, through _____, under the authority of Title 38 United States Code (U.S.C.) 7406. During your period of appointment to our facility, you will be paid by VA using a disbursement agreement with _____(*the name of the affiliated school*) and will be authorized to perform services as directed by your SLVHCS Site Director.

Acceptance of this letter, as signified by your signature below, and completion of the Standard Form (SF) 61 prior to the start of your training, serves as your appointment authorization for this training period. If you have prior federal service, you are requested to report to our Human Resources Management Office within 14 days of the beginning of your rotation for additional appointment information and processing. Please bring this letter with you, as well as any documents you may have relating to your prior federal service.

Sincerely yours,
/s/
Inger Alston
Chief, Human Resources Management Service

_____ _____
(Signature) (Date)

_____
(Printed or Typed Name)

_____
(Home Address)

_____
(School and Program)

OMB Number: 2900-0205
Estimated Burden: 30 minutes

Department of Veterans Affairs

APPLICATION FOR HEALTH PROFESSIONS TRAINEES

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs (VA) to determine your eligibility for appointment. Type or print in ink. If additional space is needed, please attach a separate sheet and refer to items being answered by number. Applications for clinical training programs may require additional information. All information required by the training program to which you are applying, as well as information requested on all application forms, must be included.

VA must protect the safety of our patients. Therefore, at some point in the appointment process, you will be asked questions about your physical and mental health. This includes questions as to whether you have received tuberculin testing, hepatitis B vaccinations or any other vaccinations.

1A. NAME (Last, First, Middle)		1B. OTHER NAMES USED	
2. PRESENT ADDRESS (Include ZIP Code)		3A - PRIMARY PHONE (Include area code) 3B - ALTERNATE PHONE (Include area code)	
4. SOCIAL SECURITY NUMBER	5A. PRIMARY EMAIL ADDRESS	5B. ALTERNATE EMAIL ADDRESS	6. DATE OF BIRTH (mm/dd/yyyy)
7A. VA TRAINING FACILITY (City, State)	7B. VA TRAINING START DATE (mm/yyyy) ☐ UNKNOWN	7C. VA TRAINING END DATE (mm/yyyy) ☐ UNKNOWN	

II - U.S. MILITARY DUTY STATUS

8A. ARE YOU NOW IN U.S. MILITARY?	8B. ARE YOU IN THE RESERVES OR NATIONAL GUARD?	8C. BRANCH OF SERVICE
☐ YES *(If YES, complete 8c)* ☐ NO	☐ YES *(If YES, complete 8c)* ☐ NO	

III - CITIZENSHIP

9A. CITIZENSHIP	9B. COUNTRY OF CITIZENSHIP
☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 9B)	

NOTE: Complete items 10A, 10B, 10C, or 10D ONLY if you are NOT a U.S. citizen.

10A. IMMIGRANT	**10B. EXCHANGE VISITOR**		**10C. OTHER NON-IMMIGRANT**		**10D. FORM DS2019**
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? ☐ YES ☐ NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (MM/DD/YYYY)

IV- THIS SECTION TO BE COMPLETED BY DESIGNATED EDUCATION OFFICER (DEO) OR DESIGNEE

11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL).	☐ YES ☐ NO
11B. Incomplete items on the TQCVL have been addressed and resolved.	☐ YES ☐ NO
11C. Special attention has been given to the following items from the application forms.	
11D. Comments:	
11E. This applicant has been approved for appointment.	☐ YES ☐ NO
11F. Comments:	

12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	12B. TITLE	12C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION

13A. LIST ALL LICENSES, CERTIFICATIONS,AND REGISTRATIONS, INCLUDING THE DRUG ENFORCEMENT AGENCY (DEA), THAT YOU HAVE NOW OR HAVE HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	13B. STATE ISSUING LICENSE	13C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	13D. EXPIRATION DATE (MM/DD/YYYY)

VI- LICENSE, CERTIFICATION, OR REGISTRATION IN OTHER/PREVIOUS CLINICAL PROFESSION(S)

14A. LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC.	14B. STATE ISSUING LICENSE	14C. LICENSE, CERTIFICATION OR REGISTRATION NUMBER	14D. EXPIRATION DATE (MM/DD/YYYY)

15. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)

The following two questions apply to both your current health profession and any prior health profession.

16. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (INCLUDING DEA CERTIFICATE) REVOKED, SUSPENDED, DENIED, RESTRICTED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED A LICENSE, CERTIFICATION, OR REGISTRATION IN LIEU OF FORMAL ACTION? ☐ YES - EXPLAIN IN PART XI ☐ NO

17. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR PLACED ON A PROBATIONARY STATUS, OR HAVE YOU EVER VOLUNTARILY RELINQUISHED CLINICAL PRIVILEGES IN LIEU OF FORMAL ACTION? ☐ YES - EXPLAIN IN PART XI ☐ NO

VII - EDUCATION AND TRAINING AFTER HIGH SCHOOL THROUGH GRADUATE / PROFESSIONAL SCHOOL (Continue in Part XI if necessary)

18A. NAME OF SCHOOL	18B. ADDRESS (City, State, and Zip Code)	18C. START DATE (MM/YY)	18D. (EXPECTED) COMPLETION DATE (MM/YY)	18E.DIPLOMA, DEGREE, OR CERTIFICATE AWARDED OR IN PROGRESS	18F. MAJOR FIELD OF STUDY

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

19A. ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? ☐ YES ☐ NO	19B. EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	19C. ECFMG CERTIFICATE DATE

IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING

20A. NAME OF HOSPITAL OR INSTITUTION	20B. ADDRESS (City, State and ZIP Code)	20C. SPECIALTY	20D. START DATE (MM/YY)	20E.(EXPECTED) COMPLETION DATE (MM/YY)	20F. NUMBER OF MONTHS COMPLETED

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

X - ADDITIONAL QUESTIONS

ITEM	PLACE AN 'x' IN APPROPRIATE SPACE. IF YES, EXPLAIN DETAILS IN PART XI	YES	NO
21	AS A PARTICIPANT IN THE MEDICARE AND MEDICAID PROGRAMS, HAVE YOU EVER BEEN CONVICTED OF OR INVESTIGATED FOR MAKING FALSE, FICTITIOUS, OR FRAUDULENT STATEMENTS, REPRESENTATIONS, WRITINGS, OR DOCUMENTS REGARDING THE DELIVERY OF OR PAYMENT FOR HEALTH CARE BENEFITS, ITEMS OR SERVICES THAT WOULD BE IN VIOLATION OF THE CRIMINAL FALSE CLAIMS ACT?	◯	◯
22	ARE YOU NOW, OR HAVE YOU EVER BEEN, INVOLVED IN ADMINISTRATIVE, PROFESSIONAL, OR JUDICIAL PROCEEDINGS IN WHICH MALPRACTICE ON YOUR PART WAS ALLEGED? If yes, give details in Part XI, including name of action or proceedings, date filed, court or reviewing agency, and the status or outcome of the case concerning those allegations. Please also provide your explanation of what occurred. As a provider of health care services, the VA has an obligation to exercise reasonable care in determining that applicants are properly qualified. It is recognized that many allegations of professional malpractice are proven groundless. Any conclusion concerning your answer as it relates to professional qualifications will be made only after a full evaluation of the circumstances involved.	◯	◯
23	Do you need accommodations to perform the procedures and essential functions of the training position for which you have applied?	☐	☐

XI - REMARKS

ITEM NO.	(Include additional information requested in items above. Be sure to indicate Item number on Form to which the comment refers.)

XII - CERTIFICATION

I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF MY STATEMENTS ARE TRUE, CORRECT, COMPLETE, AND MADE IN GOOD FAITH.

NOTE: A false statement on any part of your application may be grounds for not hiring you, or for terminating you after you begin work. Also, you may be punished by fine or imprisonment (U.S. Code, Title 18, Section 1001).

24A. SIGNATURE OF APPLICANT (sign in dark ink)	24B. DATE (mm/dd/yyyy)

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- ☐ Authorize VA to make inquiries about me to current and previous employers, educational institutions, state licensing boards, professional liability insurance carriers, other professional organizations or persons, agencies, organizations, or institutions listed by me as references, and to any other sources which VA may deem appropriate or be referred by those contacted;
- ☐ Authorize release of such information and copies of related records and documents to VA officials;
- ☐ Release from liability all those who provide information to VA in good faith and without malice in response to such inquiries;
- ☐ Authorize VA to disclose to such persons, employers, institutions, boards, or agencies identifying and other information about me to enable VA to make such inquiries; and
- ☐ Authorize VA to share any information about me with the affiliated institution or training program official.

SIGNATURE OF APPLICANT	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

Public reporting burden for this collection of information is estimated to average 30 minutes, including the time for reviewing instructions, searching existing data sources, gathering data, completing, and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to VA Clearance Officer (005R1B), 810 Vermont Avenue NW, Washington, DC 20420. Do not send applications to this address.

AUTHORITY: The information requested on this form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected to determine your qualifications and suitability for appointment to a VA clinical training program. If you are appointed by VA, the information will be used to make pay and benefit determinations and in personnel administration processes carried out in accordance with established regulations and systems of records.

ROUTINE USES: Information on the form may be released without your prior consent outside the VA to another federal, state or local agency. It may be used to check the National Practitioner Health Integrity and Protection Data Bank (HIPDB) or the List of Excluded Individuals and Entities (LEIE) maintained by Health and Human Services (HHS), Office of Inspector General (OIG), or to verify information with state licensing boards and other professional organizations or agencies to assist VA in determining your suitability for a clinical training appointment. This information may also be used periodically to verify, evaluate, and update your clinical privileges, credentials, and licensure status, to report apparent violations of law, to provide statistical data, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may be released without your prior consent to federal agencies, state licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to state licensing boards and the National Practitioner Data Bank. Information will be stored in a confidential and secure VA database for purposes of processing your application and may be verified through a computer matching program. Information from this form may also be used to survey you regarding employment opportunities in VA and to solicit you perceptions about your clinical training experiences at VA and non-VA facilities.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Completion of this form is mandatory for consideration of your application for a clinical training position in VA; failure to provide this information may make impossible the proper application of Civil Service rules and regulations and VA personnel policies and may prevent you from obtaining employment, employee benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your Social Security Number (SSN) is mandatory to obtain the employment and benefits that you are seeking. Solicitation of the SSN is authorized under provisions of Executive Order 9397 dated November 22, 1943. The SSN is used as an identifier throughout your Federal career. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records, 'Applicants for Employment' under Title 38, U.S.C.-VA (02VA135), in the 2003 Compilation of Privacy Act Issuances. The SSN will also be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is necessary because of the large number of Federal employees and applicants with identical names and birth dates whose identities can only be distinguished by the SSN.

DEPARTMENT OF VETERANS AFFAIRS
Southeast Louisiana Veterans Health Care System
P.O. Box 61011
New Orleans LA 70161-1011

In Reply Refer To: 629/002C

MEDICO-LEGAL RESPONSIBILITIES OF HOUSE STAFF

Medico-Legal Responsibilities of House Staff under the Federal Tort Claims Act, the Government is liable for the malpractice of its employees acting within the scope of their employment. For purposes of this Act, residents are considered to be employees and 38 U.S.C. 7316 applies; however, because of the variety of conditions and situations which exist, Regional Counsel will be consulted in any situation respecting the adequacy or applicability of malpractice coverage for residents. The following administrative precautions will be exercised (see also 38 U.S.C. 7316, 28 USC 2679, and 38 CFR 14.605). More information may be found here: http://vaww.ogc.vaco.portal.va.gov/law/ftca/default.aspx

Residency members must be informed that they are not protected by the Federal Government in the event of malpractice, negligence, or any other claims against them in consequence of their activities during a period of assignment to non-VA institutions. This notification will be made a matter of record and placed on the left side of each residency member's official personnel folder.

_____
Print Name

_____ _____
Signature Date

Please fill out the necessary information which is required from the "VA FORM 0711 REQUEST FOR PERSONAL IDENTITY VERIFICATION"

PRINT CLEARLY

Name: (Last, First, MI): _____

Date of Birth (XX/XX/XXXX): _____

Social Security Number (XXX-XX-XXXX): _____

Mobile phone (XXX-XXX-XXXX): _____

Email: _____

Name of VA Supervisor (*If assigned*): _____

Gender: [ ] Male [ ] Female

Race: (*choose one only*) ☐ American Indian ☐ Black-Non-Hispanic ☐ Caucasian ☐ Asian/Pacific Islander ☐ Hispanic

Height (X'X"): _____

Weight (pounds): _____

Eye color: (*choose one only*) ◯ black ◯ green ◯ blue ◯ hazel ◯ brown ◯ gray ◯ multicolored

Hair color: (*choose one only*) ◯ black ◯ white ◯ blonde ◯ none ◯ brown ◯ gray ◯ red

Place of Birth (*CITY and STATE*): _____

Place of Birth (*CITY and STATE*): _____

APPOINTMENT AFFIDAVITS

Resident/Fellow _____ _____
(*Position to which Appointed)* *(Date Appointed)*

Southeast Louisiana VA HCS _____ New Orleans, LA
(Department or Agency) *(Bureau or Division)* *(Place of Employment)*

I, _____, do solemnly swear (or affirm) that--

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO THE PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____
(Signature of Appointee)

Subscribed and sworn (or affirmed) before me this___ day of _____ , 2_____

at _____ _____
(City) (State)

_____
(Signature of Officer)

(SEAL)

Commission expires_____ _____
(If by a Notary Public, the date of his/her Commission should be shown) (Title)

Note - If the appointee objects to the form of the oath on religious grounds, certain modifications may be permitted pursuant to the Religious Freedom Restoration Act. Please contact your agency's legal counsel for advice.

Attachment A
Numbered Memorandum 00-4

From: SLVHCS Health Professions Trainee

To: Southeast Louisiana Veterans Health Care System Director (00)

Subj: Patient Abuse or Mistreatment

1. I have received, understand, and will abide by the provisions of Numbered Memorandum 00-4, "Protection of Patients from Abuse". I will not abuse any patient and will not tolerate it happening in my presence.

2. If patient abuse is witnessed, perceived, or suspected, I will immediately report it to my supervisor and/or appropriate management official (i.e. Charge Nurse, Clinic Managers, Service Chiefs, etc.).

3. I will immediately complete Part I of VA Form 10-2633, Report of Special Incident Involving a Beneficiary, giving a detailed account of the circumstances.

4. I will cooperate fully with any investigation into patient abuse.

_____	_____	_____
Print Name	Signature	Date