DIVERSITY INFORMATION

The following data is required to complete HFHS equal opportunity and affirmative action record keeping and reporting. ***Please complete and return with your signed contract***. Thank you.

Date: _____

Print Name: _____

Signature: _____

GME Program: _____

GENDER: ☐ Male ☐ Female

RACE / ETHNIC GROUP:

☐ **Hispanic or Latino** - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

☐ **White (Not Hispanic or Latino)** - A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ **Black or African American (Not Hispanic or Latino) –** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)** - A person having origins in any of the peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino)** - A person 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 Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino)** - A person having origins in any of the original peoples of North and South America (including Central America), and who maintain tribal affiliation or community attachment.

☐ **Two or More Races (Not Hispanic or Latino) -** All persons who identify with more than one of the above five races.

Qualified applicants are considered for employment, and employees are treated during employment, without regard to race, color, religion, sex, national origin, age, marital status, medical condition, or disability. Please complete this information to assist us in complying with equal opportunity/affirmative action record keeping and reporting requirements. This Information Form will be kept in a separate, confidential file and will be used only for safety and government reporting purposes.

MEDICAL LICENSES

You must be licensed by the State of Michigan before you may begin your residency or fellowship program. Please complete the appropriate process and *type or print your legal name exactly the same on all forms*.

NEW DO MICHIGAN EDUCATIONAL LIMITED LICENSE

1. **Michigan Educational Limited Licenses Application**
   - Complete the **State of Michigan Application for Educational Limited and Controlled Substance Licenses**.
   - Complete the **Certification of Appointment to a Michigan Training Hospital,** Section I only and print your name in the box on page 2.
   - **If you do not have a US Social Security Number**: Also submit a letter stating that you are resident of a foreign county (sample enclosed).
   - **Obtain a Certified Check or Money Order, payable to the STATE OF MICHIGAN for $170 US**. This fee will be reimbursed to you in August.
   - ***Return these forms and the check or money order to the Henry Ford Hospital GME Office*.** HFH will submit your application to the State of Michigan – Board of Medicine.

2. **Fingerprint Request Form Instructions**
   - Follow instructions provided and *have an ink fingerprint performed*. There are two different forms: one to use if you are in Michigan; another if you are out-of-state or country.
   - It is important that you **do this immediately**. The State of Michigan will NOT process your license application until they receive your fingerprints and criminal background check report.

3. **Certification of Internship**
   - If you are/have completed an Internship, complete the **Certification of Internship,** Section I only and print your name in the box on page 2.
   - Provide to your Director of Medical Education of the hospital which you are/have served your internship; ask that they complete and it submit directly to the Michigan Department of Licensing & Regulatory Affairs, Board of Osteopathic Medicine & Surgery, PO Box, 30670, Lansing, MI 48909.
   - It is important that you **do this immediately**. The State of Michigan will NOT process your license application until they receive your medical school certification.

4. **Medical School Certification of Medical Education**
   - Request from your medical school, to be sent directly to Michigan Department of Licensing & Regulatory Affairs, Board of Osteopathic Medicine & Surgery, PO Box, 30670, Lansing, MI 48909: Either, (1) final transcripts or (2) an official letter of good standing, written not more than 90 days prior to your date of graduation.
   - It is important that you **do this immediately**. The State of Michigan will NOT process your license application until they receive your medical school certification.

5. **Verification of Licensure in Another State**
   - If you currently hold, or have ever held a full or permanent medical license in another state, verification of the license status must be received directly from the other state to the State of Michigan –Board of Medicine. **Contact the Board of Medicine in the state where you hold/held a full or permanent license for instructions**; most states charge a fee.

RENEWING YOUR DO MICHIGAN EDUCATIONAL LIMITED LICENSE

1. If you have a **Michigan Educational Limited Licenses**, **please go to** https://mylicense.mdch.state.mi.us/MyLicenseEnterpriseDCH/Login.aspx; **read all instructions carefully, change the hospital to Henry Ford Hospital, when renewing your license and *provide the HFH GME Office a copy of your application confirmation.*** The HFH GME Office will reimburse you in August for the cost of the renewal.

2. Complete the **Certification of Appointment to a Michigan Training Hospital,** Section I only and print your name in the box on page 2. ***Return this form to the Henry Ford Hospital GME Office*.**

DO MICHIGAN FULL MEDICAL LICENSE

1. If you have a **Michigan Full Medical License** that is not expiring in advance of your start date, please scan ***and send the license and the Controlled Substance License to the HFH GME Office***.

2. Upon receipt of your final Educational Limited Medical License (a total of six are allowed), you must apply for a Full Medical License at the next renewal date.

APPLYING FOR A DO MICHIGAN FULL MEDICAL LICENSE

1. If you are applying for a **Full Medical License, please go to** https://mylicense.mdch.state.mi.us/MyLicenseEnterprise/Login.aspx; **read all instructions carefully and *provide the HFH GME Office a copy of your application confirmation*.**

2. Apply for both a Michigan Controlled Substance License and an independent Federal DEA number. The Federal DEA number application may not be made until the Full Medical License is received.

3. You are responsible for ensuring that your Full Medical License, Controlled Substance License and DEA number are renewed at the appropriate time.

4. Upon receipt of your Full Medical License, Controlled Substance License and DEA Number, ***please scan and send to the HFH GME Office***.

5. The Medical Education Office will reimburse you $170 in August.

Michigan Department of Licensing and Regulatory Affairs
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

APPLICATION FOR EDUCATIONAL LIMITED AND CONTROLLED SUBSTANCE LICENSES

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone (313)-234-4300).

Board Use Only

License Number

CS License Number

Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☐ **Educational Limited and Controlled Substance Fee: $170.00 71 - 5101- 375705**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Daytime Phone Number

Have you ever held a health professional license in Michigan? ☐ Yes ☐ No	Michigan Health Professional I.D./License Number and Expiration Date

All Previous Names and/or Birth Name Used (if applicable)

Name of Appointing Hospital	Hospital Street Address	

City	State	ZIP Code

Check the appropriate answer to each of the following questions. NOTE: Submit a detailed explanation for any YES answer you check on a separate sheet with your application.

1. **Have you ever been convicted of a felony?**	☐ Yes	☐ No
2. **Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?**	☐ Yes	☐ No
3. **Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?**	☐ Yes	☐ No
4. **Have you been treated for substance abuse in the past 2 years?**	☐ Yes	☐ No
5. **Have you had 3 or more malpractice settlements, awards, or judgments totaling $200,000 in any consecutive 5 year period?**	☐ Yes	☐ No
6. **Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?**	☐ Yes	☐ No
7. **Have you ever had a federal or state osteopathic license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?**	☐ Yes	☐ No
8. **Have you ever been censured, or requested to withdraw from a health care facility's staff or had your heath care facility staff privilege involuntarily modified?**	☐ Yes	☐ No

Name

9. Do you hold or have you held a medical license in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office.** **(Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License Number	Date of Issue	How Obtained (Endorsement or Examination)

Provide a complete chronological record of your educational preparation.
Attach additional sheets if necessary

Name and Address of Institution	Dates of Attendance From	To	Degree

Provide a description of your intern training experience.
Attach additional sheets if necessary

Name and Address of Hospital	Dates of Practice From	To	Program Title

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Licensing and Regulatory Affairs
Board of Osteopathic Medicine and Surgery
P.O. Box 30192
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

CERTIFICATION OF APPOINTMENT TO A MICHIGAN TRAINING PROGRAM

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Program Director or Superintendent of the Michigan training hospital where you have been appointed. This certification must be completed and submitted to the Board of Osteopathic Medicine and Surgery by the hospital.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name

Social Security Number	Date of Birth

Hospital Street Address		

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Program (Internship or Residency)

Name of Hospital

Signature of Applicant	Date

APPLICANT: UPON COMPLETION OF SECTION I, SEND THIS FORM TO THE PROGRAM DIRECTOR OR SUPERINTENDENT FOR COMPLETION OF SECTION II.

Name

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR/SUPERINTENDENT

INSTRUCTIONS FOR COMPLETING SECTION II:

Please complete the following information. Return this completed certification directly to the Michigan Board Osteopathic Medicine at the address shown on the reverse side of this form.

SECTION II - CERTIFICATION OF APPOINTMENT

Name of Training Hospital		
Street Address of Training Hospital		
City	State	ZIP Code

Is this training program approved by the AOA?

☐ **Yes** ☐ **No**

I certify that _____ **has been duly**
(Applicant's Name)

appointed to the position of _____ **in** _____
(Internship or Residency) (Program)

at the hospital named above beginning _____ **and ending** _____.
(Month/Day/Year) (Month/Day/Year)

_____ _____
Signature of Director or Superintendent Date of Signature

_____
Print or Type Name of Director or Superintendent

(S E A L)

If school has no seal, please indicate.

_____
Title

The Department of Licensing and Regulatory Affairs will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Sample letter **if you do not have a US Social Security Number**

To Whom It May Concern:

I, _____ am currently a resident of
(print name)

_____.
(country)

My current address in my home country is as follows:

_____

_____

_____

PLEASE SEND LICENSES TO ADDRESS ON APPLICATION

_____
Signature

_____
Date

STATE OF MICHIGAN

RICK SNYDER
GOVERNOR

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

STEVEN H HILFINGER
DIRECTOR

CRIMINAL BACKGROUND CHECK
FINGERPRINT REQUEST FORM INSTRUCTIONS- (Michigan locations only)
AGENCY ID NUMBER IS 71734k

Applicants for a Michigan health professional license may have their fingerprints taken by either L-1 Identity Solutions or Cogent Systems. Whether you use L-1 Identity Solutions or Cogent Systems, the Agency ID Number for health professional licensing is 71734k. This ID number MUST be used in order to have your fingerprint report sent to the Bureau of Health Professions. Keep the receipt you receive once your fingerprints are taken.

You must bring the Livescan Fingerprint Request Form (attached) and a driver's license or other state or federal-issued picture identification to your fingerprint appointment. You will also be required to pay a separate fee to the fingerprinting agency when registering for or scheduling your appointment.

When your fingerprints are taken, a technician will perform a scan of your fingerprints and submit the data electronically to the Michigan State Police. If no criminal history is found, the Bureau of Health Professions will be notified. If criminal history information is found, the Michigan State Police will send the record directly to the Bureau of Health Professions for review.

Information about fees and scheduling your fingerprint appointment with L-1 Identity Solutions can be found at www.L1enrollment.com or by calling 1-866-226-2952.

Information about fees and registering to have your fingerprints taken by Cogent Systems can be found at www.cogentid.com/index.htm. Click on Michigan and then select the Cogent MAPS (Michigan Applicant Processing Service) option. If you are using Cogent Systems, the MAPS option must be used for health professional licensing purposes. Cogent Systems can be reached by phone at 1-877-838-4903. E-mail inquiries about using Cogent Systems may be sent to mihelp@cogentsystems.com.

L-1 Enrollment Services is now Safran Morpho Trust

L-1 IDENTITY SOLUTIONS™
ENROLLMENT SERVICES DIVISION

1650 Wabash, Suite D
Springfield, IL 62704
Phone: 217-793-2080
Fax: 217-793-0141
www.L1id.com

If you are not in Michigan, use these Procedures

Non Resident Live Scan Processing Procedures

Applicants who reside in an area where no **L-1 Enrollment Services (L-1)** Live Scan machines are available may use **L-1's** Live Scan Processing Program. This program utilizes advanced scanning technology to convert a traditional fingerprint card (hard card) into an electronic fingerprint record. Converting a "hard card" into an electronic record enables an applicant to have their fingerprint record processed as quickly as if they had traveled to a LiveScan machine. The section below details the procedures for submitting fingerprints to the LiveScan Processing Unit.

Michigan Licensing

- Applicants should obtain a set of fingerprints from a local law enforcement agency or other entity that provides fingerprinting services. These fingerprints may be either traditional ink rolled fingerprints or LiveScan fingerprints.
- Fingerprints may be submitted on FBI applicant cards or fingerprint cards from any other state or local government agency (we prefer standard FBI applicant cards).
- Applicants need to make sure the fingerprint card is completely filled out. Required information includes: Full name, date of birth, home address, sex, height, weight, hair color, eye color, place of birth (state or country only), citizenship, reason fingerprinted and ORI (Agency ID number or MSP Requester ID number).
- Applicants will need to mail a copy of the appropriate Michigan form (Live Scan Fingerprint Request Form, Long Term Care Workforce Background Check Form or Licensing Record Clearance Request Form) with the fingerprint card.
- **Failure to completely fill out the information on the fingerprint card or failure to provide the appropriate Michigan Form (Live Scan Fingerprint Request Form, Long Term Care Workforce Background Check Form or Licensing Record Clearance Request Form) will result in the card being returned to the applicant, which will delay the licensing process**.
- The fully completed card, along with the, Live Scan Fingerprint Request Form, Long Term Care Workforce Background Check Form or Licensing Record Clearance Request Form and appropriate fee (indicated in the application packet) should then be mailed to the following address: ***L-1 Enrollment Services/Live Scan Processing Unit, 1650 Wabash Suite D, Springfield, IL 62704***. Please include a daytime telephone number or email address where the applicant can be reached if we have a question about the fingerprint card.
- Please include the full name of the applicant on each check or money order.
- Applicants wishing to verify that a fingerprint card has been processed may call 866-226-2952 and speak with a customer service representative.

L-1 Enrollment Services is now Safran Morpho Trust

Michigan Department of Licensing and Regulatory Affairs
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

LARA/300L (04/11)

LIVESCAN FINGERPRINT REQUEST FORM

Fingerprint Date:	TCN:

Type of I.D. Presented:	Type of Licensure/Registration:

Applicant Instructions: Take this completed form along with your picture I.D. to your scheduled appointment. Please print clearly.

First Name:	Middle Name:	Last Name:

Street Address:		

City:	State:	ZIP Code:

Daytime Telephone Number w/ Area Code:	State or Country of Birth:

Date of Birth (MM/DD/YYYY):	Race:	Sex:

Height:	Weight:	Eye Color:	Hair Color:

REQUESTING AGENCY INFORMATION

Agency I.D. Number:	Agency Name:
71734k	Department of Licensing and Regulatory Affairs, Bureau of Health Professions

Reason Fingerprinted:	Cost:
LHP - Licensed Health Care Professional (MCL333.16174)	

Disclaimer: Any and all errors that result in dual fingerprinting (Duplicate transmission to MSP), multiple fingerprint codes, fingerprints processed with incorrect fingerprint codes/reasons, etc., are the responsibility of the **LIVESCAN AGENCY. **MSP** will charge for dual fingerprinting (transmission), etc.

Michigan Department of Licensing and Regulatory Affairs
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

CERTIFICATION OF INTERNSHIP

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Medical Director or Superintendent of the training hospital where you served your internship. This certification must be submitted directly to the Michigan Board of Osteopathic Medicine and Surgery by the Director of the training program.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Hospital Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Name of Hospital

Signature of Applicant	Date

Applicant: **Upon completion of Section I, send this form to the Medical Director or Superintendent of the training hospital where you served your internship for completion of Section II.**

Name

THIS SIDE TO BE COMPLETED BY THE MEDICAL DIRECTOR OR SUPERINTENDENT

SECTION II - CERTIFICATION OF INTERNSHIP

Please complete the following information. Return this completed certification directly to the Michigan Board of Osteopathic Medicine and Surgery at the address shown on the reverse side of this form.

Name of Hospital		
Street Address of Hospital		
City	State	Zip Code

Is this internship AOA approved?

☐ Yes ☐ No

I certify that _____
(Applicant's Name)

has completed one year of internship at the above named hospital beginning _____
(Month/Day/Year)

and ending _____.
(Month/Day/Year)

I certify that this internship is one year in duration; of a rotating type, with rotations in the organized departments of Medicine, Surgery, Obstetrics and Gynecology; and that this Hospital is currently approved for the training of interns by the American Osteopathic Association. I further certify that the above named physician has served an apportioned time in each of the named rotations and has satisfactorily performed his/her duties.

_____
Signature of Medical Director or Superintendent

_____ _____
Print or Type Name Date of Signature

_____ (S E A L)
Title

If hospital has no seal, please indicate

IMPORTANT: This certification may not be dated and submitted more than fifteen (15) days prior to the completion of a full year's internship.

HENRY FORD HOSPITAL
GRADUATE MEDICAL EDUCATION

NPI NUMBER INSTRUCTUIONS

Residents and Fellows training at Henry Ford Hospital (HFH) **must** have an NPI number on file with the Medical Education Office.

If you already have an NPI number, please email it to your program coordinator and the GME Office. **If you do not have an NPI number,** please apply as soon as possible.

- **If you have both your Medical License Number and your Social Security Number,** apply as a Resident.
- **If you do not yet have your Medical License Number,** apply as a Student. When you get your Medical License Number you will go back to the NPI site and update the information.
- **If you do not have a Social Security Number (SSN)** you will need to apply for your NPI ***after*** you receive your SSN card. The Medical Education Office and your program coordinator will have information on how to apply for the NPI number once you are eligible.

How to apply for your NPI

1. For on-line application click here: https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.npistart This will take you to the NPPES website (National Plan and Provider Enumeration System).

2. At the top of the next page you will see "Need an NPI ----- apply on line". Click on the 'apply on line' prompt for complete instructions, including the types of documents you will need to have before you apply. You will not be able to complete your application without the required documents and you are not able to save your work if you quit before you complete the application. "Begin Application Form."

3. Complete Application Security Check.

4. The next page will prompt you to create a user I.D. and password and several security questions. **Write down this information;** you will need it throughout your professional career. At no time will HFH Administration or the residency program have access to your NPI User ID, Password or Security questions.

5. The next page will prompt you to indicate if you are a type 1 user (individual).

6. Continue to the next page to complete demographic information. The contact information you enter will be public.
   If you are applying as a resident, *we strongly advise* that you use the address and phone number for HFH in #8 (below), to protect your privacy.
   If you are applying as a student, *we strongly advise* that you change your contact information to the HFH address below as soon as possible, to protect your privacy.

7. When asked if you are a sole proprietor state "No."

8. The domestic mailing address and domestic practice location for a Henry Ford Hospital House Officer is: **Henry Ford Hospital, Medical Education Department**
   2799 W. Grand Boulevard, Detroit, Michigan 48202-2608; Phone Number: 313-916-2600

9. If you have other National identifiers such as a UPN, Medicare or Medicaid number, please add on this page.

10. The next page will ask your taxonomy and license info.
    If you are applying as a resident, your **taxonomy is code 20**. You will then be asked to identify your specialty and to add your license number.
    If you are applying as a student, the title on the NPI application will state "Student in an organized health care education/training program" and **your taxonomy code is 39**. You can leave the License Number blank, but you will need your Social Security Number. **Once you start residency, provide your license number and change the contact information to Henry Ford Hospital** (see #8 above**),** to protect your privacy, as the site is public.

11. The license number they are asking for is your Medical License, ***not*** your controlled substance or DEA number. If you do not remember your license number, your program coordinator or the Medical Education Office staff can help you. Remember, if you do not have a license at the time that you are applying, apply as a student.

12. The next page is contact person information. You can click the gray box that states "*same as provider* "(which means **you**) or you can select your program coordinator to receive this information.

13. On the next page you will be asked to read the information and click a box indicating that you are responsible for the information. Click "submit" at the bottom of the page.

14. You will be given a tracking number and phone number for follow up.

15. Your NPI number will be sent to the contact person you identified in step 12.

Please Note: If you use personal information to register for your NPI Number, it is important that you go back and change it to Henry Ford Hospital once you arrive on campus. The NPI site is available to the public, so using the hospital address protects your privacy.

HENRY FORD HOSPITAL
GRADUATE MEDICAL EDUCATION

ACCESS REQUEST FORM INSTRUCTIONS

Please **complete ONLY the following** on the Access Request Form**:**

PAGE ONE:

1. Name
2. US Social Security Number (leave blank if you do not have one)
3. Ethnicity (required for patient electronic record system)
4. Date of Birth
5. Indicate Female or Male
6. Job Title (indicate Resident or Fellow)
7. Primary Department (name of your training program)
8. Metavision Role (indicate Resident or Fellow)
9. If you are transferring from another Henry Ford Health System hospital, please specify your current hospital and include the start date as indicated on your contract in the line "***If transfer. . .***"

This box is for Access Administration use only	
	Emp. Status:
Initial	Form u3.17 Nov 2012 — Emailed By:
Ticket #	Emailed Date:

Henry Ford Health System Information Technology

Access Request Form

*If an Email does not pop-up with the form attached, please save this form then attach to an Email and send to accessrequest@hfhs.org manually.

IDENTIFICATION: All portions of this section are to be filled out completely. Fields in red are required.

Last Name: | User ID: New users will be assigned one

First Name: | Middle Initial:

Employee ID (or Social Security Number): | Work Phone: | or Ext:

Ethnicity: | Date of Birth: | ◯ Male ◯ Female

Job Title: FELLOW | Cost Center:

Professional designation (Ph.D, MSW, CRNA, etc): | UDOC Code:

Primary location (building): HFH | Floor/Room #:

Primary department: | Will this person ever rotate through the Main Campus ER? ◉ YES ◯ NO

Additional locations/departments you can be scheduled in:

HFHS Relationship: New Employee | If other, define:

If transfer, where from & date: | Deactivation date: *(leave blank if unknown)*

Manager's Name: Lena Anderson & Margo Gonzalez

Epic Hyperspace Application Section

Note: Users will be assigned read only access until they have completed Epic training, which is requested via the Henry Ford training website.

☒ Epic Hyperspace Access | User assigned to an Epic training track? ◉ Yes ◯ No | available for physicians only ☐ Haiku ☐ Canto

Provider Type: Fellow | User site activation: Wave 3

Model Epic access after the following user (ID reccomended):

Provide additional information for Epic access (if required):

Applications (additional applications on next page)

☒ CORP ☒ E-mail Account ☒ Remote Access (Portal) ☒ CPNG ☐ Order Entry ☐ Departmental Order Entry

☒ Citrix | What Citrix applications will you be accessing?:

☒ Metavision (choose role & ICU) | Role: Fellow | ICU: Adult+NICU

☐ Invision (enter ID of model) | ☐ MPAC (enter ID of model)

Applications continued

☐ AS400 (enter ID of model) ☐ Corp. Billing (enter ID of model)

☐ Beta93-Report (enter ID of model) ☐ SIS (enter ID of model)

☒ Appt. Sched. (View only) ☐ Appt. Sched. (ASMD) ☐ PEMS ☐ TSO ☒ PANS ☐ BCBS ☐ ED PulseCheck

☐ Trans Cap ☐ BI-WEB ☐ ExcelCare ☐ Sunquest Lab ☐ Sunquest CoPath ☐ Unix (Specify in notes)

☐ Kronos Time Entry Cost center(s) for which time will be entered:

☐ Mainframe Time Entry Cost center(s) for which time will be entered:

Claims Admin *(CA)*: ☐ *(CA)* HFH ☐ *(CA)* HFMG ☐ *(CA)* Kingswood ☐ *(CA)* WBH ☐ *(CA)* Dashboard

Additional Network Information

User's CORP access needs to be modeled after (enter ID of model)

Network share access (in addition to home drive and if known)

AD/CORP Groups (if known)

Additional e-mail distribution list(s) to which the user should be added (if known):

Separate entries with a comma. *** PLEASE ADD TO: RESIDENT EMAIL GROUP

Additional notes/requests/comments

Notes:

HFHS workforce members are obligated to adhere to all HFHS information security and privacy policies, procedures and standards. Non-workforce members must adhere to all obligations of the HIPAA Business Associate Agreement and/or the contract/agreement that has been entered into between the user's employer and Henry Ford Health System.

For further information or to check the status of your request please call 248-853-3652

This form may only be submitted by an HFHS manager or supervisor and must come from their HFHS email address.

Adobe Reader version 7.0.5 or newer required for proper functionality.

Henry Ford Hospital 2013 Registration Form

BASIC & ADVANCED CARDIAC LIFE SUPPORT COURSES

You must be certified in BLS and ACLS before you may begin your training. If you have a **current American Heart Association** ACLS & BLS card, you do not have to take these courses. **Please provide copy of your certification card to the HFH GME Office**. Complete this form to register for BLS and/or ACLS at Henry Ford Hospital on the dates below.

BLS/ACLS materials will not be mailed outside the USA; they will be provided the day of course.

Please Print

Name (Last, First): _____

U.S. Mailing Address: _____

_____

E-mail Address _____

Telephone number where you may reached: (_____) _____

Degree: ☐ MD ☐ DO Residency/Fellowship Program: _____

☐ I am registering for BLS on **Wednesday June 19, 2013**. The course will take about 2 hours. Please indicate below the time you would like to start the BLS course.

PLEASE CHECK ONE:

☐ 8:00 a.m. ☐ 9:00 a.m. ☐ 10:00 a.m. ☐ 11:00 a.m.
☐ 12:00 noon ☐ 1:00 p.m. ☐ 2:00 p.m.

☐ I am registering for ACLS. This is a two-day course: **Thursday & Friday, June 20 & 21, 2013 from 7:30 a.m. to 4:30 p.m.**

Course Director: Enrique Enríquez, MD, FACEP
Course Coordinator: Marilyn Enriquez, RN, BSN, CCRN, CEN
Office: 313-916-1987 email: menriqu1@hfhs.org

GME USE ONLY

COST CENTER to be charged:

2	**0**	**2**	**1**	**6**	**5**

Graduate Medical Education Pre-Employment Health Evaluation

Prior to your contract start date, but no sooner than 30 days in advance, you must complete and pass a Pre-Employment Health Evaluation*, including drug screening and TB testing (requires you to return two days later). You are NOT eligible to start your training until this has been completed*.

To schedule your Pre-Employment Health Evaluation, please complete this form to indicate your preferences for an appointment. **Return this form *to the HFH GME Office.*** The GME Office will send confirmation of the date and time of your appointment, with further instructions.

Name: (Last, First) _____

Email Address: _____

Social Security Number: _____ Date of Birth (DOB): _____

Children are NOT ALLOWED in the Employee Health Center; please plan accordingly. Remember that you must be able to return two days later to have your TB test read. Please select a date within 32 days of your contract start date and time between 8 and 11 a.m. or 1 and 4 p.m. Indicate your first (1) and second choices (2) for **date and time**:

Choice	Date	Time	Choice	Date	Time
_____	Monday, May 20	_____	_____	Monday, June 10	_____
_____	Tuesday May 21	_____	_____	Tuesday June 11	_____
_____	Wednesday May 22	_____	_____	Wednesday June 12	_____
_____	Friday, May 24	_____	_____	Friday, June 14	_____
_____	Tuesday May 27	_____	_____	Monday, June 17	_____
_____	Wednesday May 29	_____	_____	Tuesday June 18	_____
_____	Friday, May 31	_____	_____	Wednesday June 19	_____
			_____	Friday, June 21	_____
_____	Monday, June 3	_____	_____	Monday, June 24	_____
_____	Tuesday June 4	_____	_____	Wednesday June 26	_____
_____	Wednesday June 5	_____	_____	Friday, June 28	_____
_____	Friday, June 7	_____	_____	Monday, July 1	_____

Preferred Employee Health Center: _____ Henry Ford Hospital, Detroit Main Campus

_____ Henry Ford West Bloomfield Hospital

IF you are unable to keep your appointment because of circumstances beyond your control, OR
IF you are unavailable on any of the dates listed, please contact Employee Health at 313-916-4820, Option 1, or email wmoore1@hfhs.org.

Henry Ford Hospital Housing Information

HOUSING OPTIONS

There are basically three types of housing you will want to consider: 1) Hospital-owned and operated apartments; 2) Privately owned and operated rental housing consisting primarily of apartments, townhouses and single-family homes; and 3) Housing available for purchase consisting of apartment/townhouse condominiums and single-family homes. Information regarding these options is provided below.

Henry Ford Hospital Properties

Accommodations:
The hospital-owned properties include the Henry Ford Hospital (HFH) apartment building, which has 160 apartments. The apartment building has one and two bedroom apartments available, both with a single bath, kitchen, living/dining area and private balcony. One-bedroom apartments are approximately 635 sq. ft. and two bedroom apartments are 875 sq. ft. Closet-storage is available in the apartment.

Location and Parking:
The HFH apartment building is located directly behind the hospital and provides convenient access to the hospital and its facilities. Free parking is provided in a fenced surface lot surrounding the apartment building.

Furnishings:
The apartments are unfurnished. Carpeting and vertical blinds are provided in all units and may not be replaced or removed. All units have neutral wall-to-wall carpeting and off-white walls.

Appliances:
A stove, refrigerator, and sink disposal is provided in the apartments. Some units have built-in microwaves and dishwashers. In addition, a card-operated laundry facility is conveniently located on the first floor of the apartment building. Unfortunately, there are no connections for washers and dryers in the apartments.

Utilities:
All utilities, with the exception of telephone service, are included in the rent. The units are air-conditioned and have individual heat control. All apartments units have at least one telephone outlet and service is ordered through numerous local providers. The apartments are cable ready and cable television may be ordered through Comcast Cablevision.

Eligibility:

To be eligible for Henry Ford Hospital housing, you must be actively enrolled in a residency-training program. Exemptions may be granted based on unusual circumstances if availability permits. Family members of the physician-in-training may also reside in HFH housing provided that certain limitations are observed. A maximum of two tenants are permitted in the one-bedroom apartments and four tenants in the two bedroom apartments. All adult tenants must be co-signers on the lease. Guest occupants are permitted for short periods of time.

Rental Rates:

The rental rates for hospital housing properties are very competitive with local market rates. **HFH Apartments do not qualify for the Live Midtown program.** Rent payments are deducted from the resident's paycheck on a bi-weekly basis. See application from for required deposit information. All apartments facing south are satellite accessible and are rented at a higher rental rate. Rates are

Floor	One Bedroom Unit Unfurnished 635 sq. ft. Bi-Weekly Rate	Two Bedroom Unit Unfurnished 875 sq. ft. Bi-Weekly Rate
03 - 07	$270 - $305	$328 - $360
08 - 14	$279 - $314	$334 - $367
15 - 21	$284 - $321	$340 - $374

Liability Insurance:

Henry Ford Hospital shall not be liable to damages for any personal injury or loss unless caused by the willful neglect of the hospital. Henry Ford Hospital shall not be liable for any personal property stolen from residents or guests of residents. Residents utilize parking space, laundry space, and recreational facilities at their own risk. ***The hospital advises that residents secure insurance to protect themselves and their guests from loss or damage sustained on Henry Ford Health System premises.***

Pets:

Pets are not permitted on hospital property. **Dogs and cats are specifically prohibited**.

Penalty for Early Termination

Tenant will be liable for rental fees for the duration of the leasing contract up to 45 days prior to the contract expiration date. Tenant may find a replacement to fulfill the balance of the leasing contract. Replacement must meet eligibility requirements for occupancy in HFH Apartments.

Limited Availability:
The housing available on campus can only accommodate approximately 20% of all physicians-in-training. Additionally, housing is very limited during the summer months as out-going physicians often vacate the premises after in-coming physician must report. *Therefore, it may be necessary for you to make transition arrangements during the months of June and July*, if possible, with subsequent housing assignment in August. Housing Services will make every attempt to resolve these timing conflicts. Alternatively, if you are willing to share an apartment with another resident for one or two months, this may also facilitate your permanent housing assignment.

Assignment Policy:
The apartment building *is utilized as temporary housing quarters to assist incoming residents until they become familiar with the area*. ***There is a three-year limit on residing in HFH Apartments.*** Housing Services attempts to meet all requests regarding specific housing accommodations. This is done on a first-come, first-serve basis. Housing Services is committed, however, to accommodating as many individuals as possible and therefore, reserves the right to assign housing based on individual need, family size and/or other factors. Residents with families or who wish to share an apartment may be given priority for two-bedroom apartments. Every effort is made to accommodate your choice of apartment size and floor; however, due to the limited number of apartments that are available, it is not always possible to give you your first choice. As a general rule of thumb, one-bedroom apartments are better for single individuals; two bedrooms are better for couples or families. If there are not enough one-bedroom apartments available, you may be assigned to a two-bedroom apartment even if you request a one-bedroom apartment.

If you or a family member has a physical disability involving mobility, we will try to accommodate you in a suitable apartment. However, it is urgent that you complete your application for housing as early as possible and indicate your need for special housing.

Generally, most correspondence is transacted through email. If you do not receive a response to your housing request by 30 days prior to your requested move-in date, please contact the Housing Office:

Apartment Coordinator, Henry Ford Hospital Apartments
1350 W. Bethune, Detroit, MI 48202
(313) 916-3297 Office (313) 916-1714 Fax
dclark2@hfhs.org

Cancellation of Application:
If you wish to cancel your housing application for any reason, please notify the Housing Office at (313) 916-3297 within (30) thirty days of submitting the application. You may also notify us by email at dclark2@hfhs.org.

Private Rental Housing

A wide variety of private rental housing is available throughout the metro-Detroit area. Rental rates vary depending on the location and amenities of the complex but general, housing rates in this area are considered very competitive. Housing is available with the City of Detroit or within a relatively easy commute from surrounding communities (less than 30 minutes on well-constructed highways). Parking is available on campus without charge for commuting residents. Residents are encouraged to make their own contacts regarding private housing. Information regarding different complexes in the area is available from Apartment Search, Donna Schneck, Relocation Specialist, (or email, donna_schneck@yahoo.com. To inquire about other local opportunities please contact them directly. There is no charge to you for this service. **Many private rentals qualify for the Live Midtown program (see following information).**

Homes for Purchase

A wide variety of housing is available throughout the metro-Detroit area. Housing is available within the City of Detroit or within a relatively easy commute from surrounding communities. Purchase prices vary substantially depending on the area and the type of home. Parking is available on campus without charge for commuting residents.

A THIRD YEAR FOR LIVE MIDTOWN

For the third year in a row, the financial incentives offered through the Live Midtown program make it even more attractive and affordable to move to Midtown. Live Midtown offers financial incentives for employees of Henry Ford Health System and other Midtown anchor institutions who choose to live and invest in a Midtown residence.

At Henry Ford, Live Midtown is open to new hires and existing employees. Full-time, part-time, contingents, residents and fellows are eligible. Temporary employees, students, contract staff, contract physicians and volunteers are not eligible. Eligible employees at all Henry Ford sites can apply for Live Midtown funding.

Occupancy in Midtown is high and properties lease and sell quickly. To find a property, work with a licensed real estate broker with experience in Midtown.

Since Live Midtown began in January 2011, 154 Henry Ford employees have participated and received almost $700,000 in Live Midtown funds.

FINANCIAL INCENTIVES AVAILABLE

NEW HOMEOWNERS: $20,000 toward the purchase of a primary residence.
NEW RENTERS: $2,500 toward the cost of a new lease.
EXISTING HOMEOWNERS: Matching funds of up to $5,000 for exterior improvements for projects costing $10,000 or more.
EXISTING RENTERS: $1,000 toward a lease renewal.
Employees who received the new renter award the previous year can apply for the Existing Renter award their second year of leasing in Midtown.

LIVE MIDTOWN BOUNDARIES

To be eligible for Live Midtown, properties must lie within these boundaries:
NORTH: The properties on the north side of Philadelphia Street
EAST: I-75
SOUTH: Mack Avenue/Martin Luther King Boulevard
SOUTHWEST: Grand River Avenue
WEST: Rosa Parks Boulevard

HOW TO APPLY

For an application, log on to www.henryfordconnect.com/livemidtown and click on the “Application” button. Applications can also be accessed from www.livemidtown.org. Print and complete part one of the appropriate form and return it in person to Employee Services, 1 Ford Place, 4E, or fax to (313) 874-6380.

FOR MORE INFORMATION

- **Log onto www.henryfordconnect.com/livemidtown for:**
  - Program details
  - Key Messages
  - FAQs
  - Complete program guidelines
  - Applications
  - Map of Midtown
- **Log on to www.livemidtown.org for:**
  - A list of licensed real estate brokers in the Midtown area
  - Click on the “Contact” tab to ask a question via email
- Call Midtown Detroit, Inc. at (313) 420-6000.
- Contact Employee Services, (855) 874-7100, or via email at employeeservices@hfhs org.

Henry Ford Hospital Apartments Housing Application

To apply for HFH Apartments Housing, please print or type all information on this form and ***submit this one-page application form to the HFH GME Office.*** You will be notified when a unit is available for you.

Name: (Last, First) _____

Address/Street/Apt.: _____

City/State/Zip _____

Email Address: _____

Telephone: (where we may contact you)

Home: _____ Cell: _____

Program Department: _____

PGY (1, 2, 3, etc.): _____ Date of Birth (DOB): _____

I would like to request the following apartment as indicated below
Rank your preference for apt size and floor location with a "1" being your first choice; use a "0" to indicate an option you would not consider.

Apt Size:
_____ 1 bedroom
_____ 2 bedroom

Floor Preference:
_____ 03 - 07
_____ 08 - 14
_____ 15 - 21

Requested Move-in Date: _____ Expect to Vacate: _____

Name, relationship and age (for children) of dependents who will reside with you during your training, including spouse if applicable:

Names	**Relationship**	**Ages**

Deposits:

- A $100 non-refundable deposit is due when we confirm that housing is available, to hold your apartment. This will be applied to your Security Deposit.
- The following refundable deposits are due at move-in:
  - Security Deposit equal to one month's rent
  - Key Deposit of $10
  - A Cleaning Deposit of $200 (1 bedroom) and $250 (2 bedrooms)
  - These deposits are refundable based on condition of the apartment when vacated.

Housing will be confirmed by **email.** If you have any questions or want to cancel your request, please contact the Apartment Coordinator (313) 916-3297 or dclark2@hfhs.org .

V. 2/15/13