Welcome Packet Outline

2012/2013

Please return the following forms to Physician Service by April 11, 2012.

- Training License Process
- Health Office Requirements
- Personnel Form
- Background Investigation Form
- I-9 Employment Eligibility Verification
- W-4 Form
- Payroll Direct Deposit
- Health Insurance Enrollment Form
- Dental Insurance Enrollment Form
- Life Insurance Beneficiary Form
- Jackson Pharmacy's DEA Number
- Receipt of Meal Card
- Medical Record Signature Form
- Duty Hours Attestation
- Receipt of Florida Board of Medicine Laws and Rules
- Obtain CANEID (C-Number)
- Please Keep the Additional Pages for Your Records

Mail Packet:

Jackson Memorial Hospital
Attn: Physician Services- House Staff
East Tower, 1st Floor # 1004
1611 N.W. 12th Avenue
Miami, FL 33136-1096

- Please fill out the welcome packet with as much information as possible. Any information that is pending (Physician ID#, SS#, Local Address, ETC) can be updated once you start.
How to Apply for Initial Training Licenses
(This is only for Initial License)

You are responsible for your own licensing. You will not be able to start your training until you are issued a valid license by the Florida Board. The process takes 45-60 days so begin application as soon as possible.

- Go to this Link:
  [http://doh.state.fl.us/mqa/initial_licensure.html](http://doh.state.fl.us/mqa/initial_licensure.html)

- Click on:
  
  *Apply online for initial licensure* (You are only required to have a resident training license. If you apply for a full license Jackson will not be responsible for the license fees)

- Chose from these options the one that applies to you:
  
  - Board of Medicine
  - Board of Osteopathic Medicine
  - Board of Dentistry (No fee)

- Apply for your license. (An institutional letter will be sent directly to the Florida Board with the names of the Interns/Residents/Fellows that will be training at Jackson/UM. There is no need to request this letter from us.)

- Payment
  
  Jackson will pay for your **training license fees only**. When you reach the payment option you will use this pay code:

  - **Medical training license pay code:** 411YX0002
  - **Osteopathic training license pay code:** 411ZA0001
DRUG TEST AND PRE-PLACEMENT HEALTH REQUIREMENTS INSTRUCTIONS

All JHS employees must have a physical exam, have received immunizations and provide urine for drugs of abuse testing within 30 days of the first day at work. Applicants who do not complete health screening requirements, who are confirmed positive for illegal drugs or unauthorized use of controlled substances, or who have refused a drug test will not be allowed to begin work and will be separated from employment and the Graduate Medical Education Program. To ensure compliance and to expedite completion of physical and drug testing requirements please do the following:

1. Go to www.jhsmiami.org click on Residency/Fellowship Programs link then go to Graduate Medical Education link. Click on New Residents & Fellow link, then go to Health Office Requirements and download the following forms:
   a. Registration and Consent Form for Housestaff
   b. OHS Pre-Placement Health Screen Form
   c. OHS Medical History Statement Form
   d. Respirator Medical Questionnaire

2. Email or Fax the completed Registration and Consent Form to Occupational Health Services (OHS) prior to calling 786-466-8381 to schedule an appointment for drug testing. Note the last date to schedule in the table below.

3. Email or Fax the completed Pre-Placement Health Screen Form, Medical and Occupational History Form, and Respirator Medical Questionnaire Form to OHS as soon as possible and before the deadline in the table below. Immunization and health screening requirements are listed on the Medical and Occupational History Form.

4. Reasons and Consequences of Positive Drug Test Results: Urine is tested for narcotics, depressants, hallucinogens, stimulants, marijuana, and other controlled substances. Alcohol and Urine Drug Screening is performed according to Metropolitan Dade County Scientific and Administrative Protocol. An applicant will be considered to have a positive drug screen if any of the following criteria are met:
   a. The urine is positive for an illegal substance or a controlled substance without a valid medical prescription
   b. Breath analysis is positive for alcohol
   c. The applicant refuses to provide a test or takes any action that may delay or adulterate testing.
   d. An applicant will be reported to have “refused to provide a drug test” when the applicant:
     i. Cancels or attempts to reschedule a drug test appointment after the “last date to schedule” in the table.
     ii. Attempts to adulterate or modify the sample or test outcome

Licensed professionals who fail the drug test will be reported to the Florida Agency for Health Care Administration Licensing Board and/or to the Impaired Nurse Program or Physician Referral Network if eligible to participate. All expenses for further medical evaluations as a result of positive drug test or appeal will be the responsibility of the applicant.

DEADLINES FOR COMPLETING HEALTH SCREENING REQUIREMENTS

<table>
<thead>
<tr>
<th>Start Date at JHS</th>
<th>Last Date to Schedule Drug Test &amp; Deadline For Health Forms</th>
<th>First Available Appointment for Drug Testing</th>
<th>Last Available Appointment for Drug Testing</th>
<th>Last Date to Complete Follow-Up Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>6/24/12</td>
<td>5/14/12</td>
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## Personnel Form

<table>
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<tr>
<th>Department:</th>
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<table>
<thead>
<tr>
<th>Home Address:</th>
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<tr>
<th>Contact Number:</th>
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<thead>
<tr>
<th>Date of Birth:</th>
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<tr>
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<tr>
<th>If Not US Citizen Type of Visa:</th>
<th>ECFMG #:</th>
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### EDUCATION & TRAINING

<table>
<thead>
<tr>
<th>Medical School:</th>
<th>Graduation Date:</th>
<th>Degree Obtained:</th>
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<tr>
<th>Internship &amp; City, State, Country:</th>
<th>Dates of Training:</th>
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<tr>
<th>Previous Residency Training &amp; City, State, Country:</th>
<th>Dates of Training:</th>
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<th>Previous Residency Training &amp; City, State, Country:</th>
<th>Dates of Training:</th>
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I verify that all the above information is correct to the best of my knowledge.

Signature ___________________________ Date __________
☐ I understand that in order to complete my background screening investigation I must go [https://www.tclogiq.com/jhshousestaff](https://www.tclogiq.com/jhshousestaff) and complete all the questions on the application. I also understand that this is an employment requirement and that I may not be able to start my employment until my background investigation is complete.

Signature__________________________________________  Date________________
NOTICE REGARDING BACKGROUND INVESTIGATION
[IMPORTANT -- PLEASE READ CAREFULLY BEFORE SIGNING ACKNOWLEDGMENT]

In compliance with Public Law 91-508 (the Fair Credit Reporting Act), as amended by Public Law 104-208 (the Consumer Credit Reporting Reform Act of 1996) and applicable state law, this notice is to inform you that the Jackson Health System (JHS) may obtain information about you from a consumer reporting agency for employment and/or medical staff/health professional affiliate staff membership and/or clinical privileges purposes. Thus, you may be the subject of a “consumer report” and/or an “investigative consumer report” which may include, but not limited to, education & employment verification and criminal history check. These reports may be obtained at any time after receipt of your authorization and, if you are hired and/or medical staff/health professional affiliate staff membership and/or clinical privileges are extended, throughout your employment and/or medical staff/health professional affiliate staff membership and/or clinical privileges. You have the right, upon written request made within a reasonable time after receipt of this notice, to request disclosure of the nature and scope of any investigative consumer report. Please be advised that the nature and scope of the most common form of investigative consumer report obtained with regard to applicants for employment and/or medical staff/health professional affiliate staff membership and/or clinical privileges is an investigation into your education and/or employment history conducted by TC LogiQ, Inc., 3630 Sinton Road., Suite 306 Colorado Springs, CO 80907, Phone: (877) 825-6447, Fax: (888) 823-0371 or another outside organization. The scope of this notice and authorization is all-encompassing, however, allowing the Jackson Health System to obtain from any outside organization all manner of consumer reports and investigative consumer reports now and, if you are hired and/or medical staff/health professional affiliate staff membership and/or clinical privileges are extended, throughout the course of your employment and/or medical staff/health professional affiliate staff membership and/or clinical privileges to the extent permitted by law.

New York applicants or employees only: You have the right to inspect and receive a copy of any investigative consumer report requested by JHS by contacting the consumer reporting agency identified above directly.

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION and A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT and certify that I have read and understand both of those documents. I hereby authorize the obtaining of “consumer reports” and/or “investigative consumer reports” at any time after receipt of this authorization and, if I am hired and/or medical staff/health professional affiliate staff membership and/or clinical privileges are extended, throughout my employment and/or medical staff/health professional affiliate staff membership and/or clinical privileges. To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by TC logiQ, Inc., another outside organization acting on behalf of the Jackson Health System, and/or the Jackson Health System itself. I agree that a facsimile (“fax”) or photographic copy of this Authorization shall be as valid as the original.

Minnesota and Oklahoma applicants or employees only: Please check this box if you would like to receive a copy of a consumer report if one is obtained by the Company. ☐

California applicants or employees only: By signing below, you also acknowledge receipt of the NOTICE REGARDING BACKGROUND INVESTIGATION PURSUANT TO CALIFORNIA LAW. Please check this box if you would like to receive a copy of an investigative consumer report or consumer credit report if one is obtained by the Company at no charge whenever you have a right to receive such a copy under California law. ☐

Name: 
Social Security Number:  DOB***: 
Current Address:  
City:  State:  Zip:  
Driver’s License Number:  State:  
Signature:  Date: 

**Date of Birth is being requested in order to obtain accurate retrieval of records.
Form W-4 (2012)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete only lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $1,500 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the Personal Allowances Worksheet below. The worksheet on page 2 further adjusts your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earner/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 601, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the Personal Allowances Worksheet below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1992-2, Supplemental Form W-4 instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, see Pub. 505 to see how much the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $150,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at www.irs.gov/if4. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

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Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for yourself if no one else can claim you as a dependent.

B Enter "1" if:

- You are single and have only one job; or
- You are married, have only one job, and your spouse does not work; or
- Your wages from a second job or your spouse’s wages (or the total of both) are $1,500 or less.

C Enter "1" for your spouse. But you may choose to enter "0" if you are married and have either a working spouse or more than one job. (Entering "0" may help you avoid having too little tax withheld.)

D Enter number of dependents (other than your spouse or yourself) you will claim on your tax return.

E Enter "1" if you will file as head of household on your tax return (see conditions under head of household above).

F Enter "1" if you have at least $1,900 of child or dependent care expenses for which you plan to claim a credit.

G Child Tax Credit (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $51,000 ($80,000 if married), enter "2" for each eligible child; then less "1" if you have three to seven eligible children or less "2" if you have eight or more eligible children.

- If your total income will be between $51,000 and $64,000 ($80,000 and $119,000 if married), enter "1" for each eligible child.

H Add lines A through G and enter total here. (Note. This may be different from the number of exemptions you claim on your tax return.)

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For accuracy, complete all worksheets that apply.

- If you plan to itemize or claim adjustments to income and want to reduce your withholding, see the Deductions and Adjustments Worksheet on page 2.
- If you are single and have more than one job or are married and you and your spouse both work and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the Two-Earners/Multiple Jobs Worksheet on page 2 to avoid having too little tax withheld.
- If neither of the above situations applies, stop here and enter the number from line H on line 5 of Form W-4 below.

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Separate here and give Form W-4 to your employer. Keep the top part for your records.

Employee's Withholding Allowance Certificate

- Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.

1 Your first and middle initial

2 Your social security number

Home address (number and street or rural route)

City or town, state, and ZIP code

5 Total number of allowances you are claiming (from line H above or from the applicable worksheet on page 2)

6 Additional amount, if any, you want withheld from each paycheck

7 I claim exemption from withholding for 2012, and I certify that I meet both of the following conditions for exemption.

- Last year I had a right to a refund of all federal income tax withheld because I had no tax liability, and
- This year I expect a refund of all federal income tax withheld because I expect to have no tax liability.

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee’s signature

Date

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Cat. No. 102202Q

Form W-4 (2012)
Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-Discrimination Notice: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification (To be completed and signed by employee at the time employment begins.)

<table>
<thead>
<tr>
<th>Print Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle Initial</th>
<th>Maiden Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address (Street Name and Number)</td>
<td></td>
<td></td>
<td>Apt. #</td>
<td>Date of Birth (month/day/year)</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>Social Security #</td>
<td></td>
</tr>
</tbody>
</table>

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

☐ I attest, under penalty of perjury, that I am (check one of the following):
   - A citizen of the United States
   - A noncitizen national of the United States (see instructions)
   - A lawful permanent resident (Alien #)
   - An alien authorized to work (Alien # or Admission #)

   until (expiration date, if applicable - month/day/year)

Employee's Signature | Date (month/day/year)

Preparer and/or Translator Certification (To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Preparer/Translator's Signature | Print Name

| Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year) |

Section 2. Employer Review and Verification (To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)

<table>
<thead>
<tr>
<th>List A</th>
<th>OR</th>
<th>List B</th>
<th>AND</th>
<th>List C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document title:</td>
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<td>Expiration Date (if any):</td>
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</table>

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on (month/day/year) and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)

Signature of Employer or Authorized Representative | Print Name | Title

| Business or Organization Name and Address (Street Name and Number, City, State, Zip Code) | Date (month/day/year) |

Section 3. Updating and Reverification (To be completed and signed by employer.)

A. New Name (if applicable) | B. Date of Rehire (month/day/year) (if applicable)

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

<table>
<thead>
<tr>
<th>Document Title:</th>
<th>Document #:</th>
<th>Expiration Date (if any):</th>
</tr>
</thead>
</table>

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative | Date (month/day/year) |
***Note: The I-9 Employment Eligibility Verification must be accompanied with a clear copy of the acceptable documents list below. Any failure to submit legible documents can result in your delayed employment.

### LISTS OF ACCEPTABLE DOCUMENTS

#### LIST A
Documents that Establish Both Identity and Employment Authorization

1. U.S. Passport or U.S. Passport Card
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa
4. Employment Authorization Document that contains a photograph (Form I-766)
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien’s nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI

#### LIST B
Documents that Establish Identity

1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address
3. School ID card with a photograph
4. Voter's registration card
5. U.S. Military card or draft record
6. Military dependent's ID card
7. U.S. Coast Guard Merchant Mariner Card
8. Native American tribal document
9. Driver's license issued by a Canadian government authority
10. School record or report card
11. Clinic, doctor, or hospital record
12. Day-care or nursery school record

#### LIST C
Documents that Establish Employment Authorization

1. Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. Native American tribal document
6. U.S. Citizen ID Card (Form I-197)
7. Identification Card for Use of Resident Citizen in the United States (Form I-179)
8. Employment authorization document issued by the Department of Homeland Security

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)
To sign up for Direct deposit, you must complete the requested information and return the form to the JHS Human Resources Capital Management Personnel Records Department. New direct deposit requests have a 30-day pre-note (waiting period) with your bank once the form is processed; employees will receive regular pay checks until the time funds are directly deposited. If a correction request on the pre-note is received from your bank via the Federal Reserve, this could delay your direct deposit request.

If you close your account with the bank before stopping your direct deposit with Jackson Health System, there can be a delay of up to one week to receive your pay if the funds have been sent to a closed account. This delay is dependent on your bank returning the funds back to the issuing bank.

SECTION 1. EMPLOYEE INFORMATION  (Please Print)

Action (Check One)  □ New  □ Change  □ Cancel

Last Name  First Name  MI  Social Security Number

Company No:  Job Title  Work Location  Work Phone  Home Phone

SECTION 2. FINANCIAL INSTITUTION INFORMATION  (Please Print)

Name of Financial Institution

Address  Telephone Number

Account Type  (Circle One)  Routing Number  Account Number

Checking or Savings

You must attach a voided check (not a deposit slip) or a savings account withdrawal/deposit coupon for the account listed above where your check will be deposited. Your name must appear on either form attached. Please refer to the reverse side of this form for further information.

This authorization will remain in effect until The JHS Human Resources Capital Management Personnel Records Department receives written notification of its termination or notification of resignation. Please contact your financial institution if you wish to have your funds distributed into other accounts. The Public Health Trust is also authorized to initiate corrections, if necessary, to any amounts credited in error.

Signing below confirms your understanding and acceptance of the above stated terms. It further provides, pursuant to FS 532.04, authorization to the Public Health Trust to automatically deposit your net pay into your designated account at the financial institution indicated above.

Employee Signature: ___________________________  Date: ________________
## Jackson Residents' Plan #120200 - Employee Enrollment / Change of Status Form

### Employee Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Social Security</th>
<th>Birth Date</th>
<th>Male/Female</th>
<th>AvMed PCP Name / PCP #</th>
<th>Ethnicity (optional)</th>
</tr>
</thead>
</table>

**Home Phone**

**Work Phone**

**Occupation**

**Marital Status**

**Ethnicity (optional)**

**Preferred Language (optional)**

**AvMed PCP Name / PCP #**

**Are you covered by Medicare?**

- **Yes**
- **No**

- **If yes, why?**
  - **65+**
  - **Disabled**

### Dependent Information

(Attach separate sheet with dependent information if additional space is needed, sign and date)

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Social Security</th>
<th>Birth Date</th>
<th>Male/Female</th>
<th>AvMed PCP Name / PCP #</th>
<th>Ethnicity (optional)</th>
</tr>
</thead>
</table>

**Relation to Your SP / Spouse, DP / Domestic Partner, CH / Child, GC / Grandchild**

**If you are married, is your spouse currently employed?**

- **Yes**
- **No**

**If your spouse covered by another health carrier?**

- **Yes**
- **No**

**Name of spouse’s health plan:**

**If yes, why?**

- **65+**
- **Disabled**

### Employee Information Change (Applies to Subscriber)

**Check the action that applies.**

- **Name Change:**
  - Last Name ____________________________
  - First Name ____________________________
  - M.I. ____________________________

- **Address Change:**
  - Street Address ____________________________
  - Apt. # ____________________________
  - City ____________________________
  - State ____________________________
  - Zip ____________________________

- **PCP Change:**
  - Effective Date of Change ____________________________
  - AvMed PCP Name / PCP # ____________________________

**Update Social Security #:**

### Add Dependent(s)

(Attach separate sheet with dependent information if additional space is needed, sign and date)

- **Marriage Event Date:**
- **Birth Event Date:**
- **Adoption Event Date:**
- **Other Event Date:**

### Disenrollment(s)

(Attach separate sheet with dependent information if additional space is needed, sign and date)

- **Cancel Entire Coverage:**
  - Effective Date: ____________________________
  - Reason for Disenrollment: ____________________________

### Employee Signature:

**Date:** ____________________________

### Administrator Signature:

**Date:** ____________________________

**NOTE:** All eligible dependents must meet eligibility requirements as defined in the Group Contract and the Employee must provide proof of such status for the dependent eligibility to be eligible for coverage up to the maximum age specified. If dependents have attained the age threshold earlier than that of the employee, attach proof of legal supporting documents as evidence of their dependent status.

**Employee Must Sign and Date the Following Certification and Authorization:**

- **I hereby request participation under my Employee's Group Plan. The employee and all dependents and authorizations shall remain in effect until I change Plan as provided. I understand my employer has the right to limit the amount of benefits provided by the plan.**

**I understand that any person who knowingly and with intent to defraud, defraud, or deceive any insurer, file a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

- **In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the employer/insurer or its agents are required to provide notice to employee and dependents of the names, addresses, and contact information of the designated privacy officer.**

**Employee Information Form:**

- **Employee Name:** ____________________________
  - **AvMed ID#:** ____________________________

**Effective Date:** ____________________________

**Reason for Disenrollment:** ____________________________

**Employee Signature:** ____________________________

**Date:** ____________________________

**MP-5036 02-15**

**WHITE COPY – AVMED**

**YELLOW COPY – EMPLOYER**

**PINK COPY – EMPLOYEE**

**AVMED HEALTH PLANS**

**(Circle Group Number) 800-947-7440**

**(City and State) 941-493-1121**

**FAX: 941-493-1122**
Jackson Memorial Hospital

Benefits Enrollment Form

Please complete the following information:

<table>
<thead>
<tr>
<th>Social Security No.</th>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Address</td>
<td>Home Phone</td>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
<td>ZIP Code</td>
<td>Business Phone</td>
<td>Facility Number</td>
</tr>
</tbody>
</table>

List All Your Eligible Dependents That Are To Be Covered

<table>
<thead>
<tr>
<th>First</th>
<th>MI</th>
<th>Last</th>
<th>Facility Number</th>
<th>Sex</th>
<th>Birth Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spouse:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child:</td>
<td></td>
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<tr>
<td>Child:</td>
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</tr>
</tbody>
</table>

Effective Date:  
Plan Code:  
Group Number  
Your E-mail Address  
Agent Number

PLEASE CHECK YOUR CHOICE

☐ Dental Plan

Employee Only

Employee + One

Employee + Family

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan.

I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: X ___________________________ Date: ___________________
JHS LIFE INSURANCE BENEFICIARY FORM

- □ New Enrollment
- □ Change of Beneficiary
  
  **Effective Date:** _____________

  **Social Security Number:** _______________________
  **Date of Birth:** ____________

- □ Male  □ Female  
  **Marital Status:** □ Married  □ Single  □ Divorced

  **Last Name:** ________________  **First Name:** ________________  **Middle Initial:** ______

  **Mailing Address:** __________________________________________________________

  **City:** ________________  **State:** ________________  **Zip Code:** ______
  **Phone #:** ________________  **Work #:** ________________  **Ext:** ______

**GROUP LIFE INSURANCE** - The first $50,000 of coverage is at no cost to you. If you want to add an additional $50,000 for a total of $100,000 in coverage the cost is $72 a year.

Would you like to add the additional $50,000: □ Yes  □ No?

<table>
<thead>
<tr>
<th>Beneficiary Name: __________________________</th>
<th>Relationship to you: __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary □  Secondary □</td>
<td>Percentage of Benefits: ______</td>
</tr>
<tr>
<td>Address: ____________________________________</td>
<td></td>
</tr>
<tr>
<td>City: ________________  State: ________________  Zip Code: ______</td>
<td></td>
</tr>
<tr>
<td>Phone #: ________________  Work #: ________________  Ext: ______</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Beneficiary Name: __________________________</th>
<th>Relationship to you: __________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary □  Secondary □</td>
<td>Percentage of Benefits: ______</td>
</tr>
<tr>
<td>Address: ____________________________________</td>
<td></td>
</tr>
<tr>
<td>City: ________________  State: ________________  Zip Code: ______</td>
<td></td>
</tr>
<tr>
<td>Phone #: ________________  Work #: ________________  Ext: ______</td>
<td></td>
</tr>
</tbody>
</table>

Signature __________________________________  **Date:** ________________
PHYSICIAN’S PHARMACY FORM APPLICATION

PHYSICIAN NAME: ______________________________________________

PHYSICIAN ID #: ______________________________________________

SOCIAL SECURITY #: ____________________________________________

DATE OF BIRTH: ______________________________________________

SPECIALTY: ____________________________________________________

HOSPITAL DEA #: AJ0194922

MEDICAL OR TRAINING LICENSE: __________________________________

PERSONAL DEA # IF APPLICABLE: _________________________________

Pursuant to S.458.345.F.S., I hereby apply to use the hospital’s DEA registration number to be used during the course of employment at the Public Health Trust facilities ONLY. I understand that my discrete suffix will be used only by myself and will be kept in a confidential nature. I understand that the trust has the right to revoke the use of the hospital’s DEA registration at anytime. I understand that the use of the Trust’s DEA registration will be terminated upon graduation or separation from the Public Health Trust.

Signature_________________________________________ Date______________
RECEIPT OF MEAL CARD

I have received the Jackson Memorial House Staff Officer Meal Card. At the beginning of each academic year $1,375 will be issued to my meal card to be used throughout the academic year. Any money not used by the end of the academic will not carry over to the next academic year. If the card is lost, stolen or damaged there will be a $10 replacement fee.

I understand that if I exhaust all the money allocated, no money will be added to the card until the following academic year.

I further understand that if the policy is changed at any time, any such changes shall be communicated in writing and such written statement will be the controlling document.

Print Name ________________________ Signature ________________________

Department ________________________ Date ________________________

***Note: This form must be signed and returned with your welcome packet. All meal cards will be distributed with the orientation packet prior to your start date. If you do not return this form the meal card will not be included in your packet.***

AN EQUAL OPPORTUNITY EMPLOYER
Jackson Memorial Hospital

MEDICAL RECORDS SIGNATURE FORM

SIGNATURE __________________________________________________________

PRINT NAME _________________________________________________________

DEPARTMENT _________________________________________________________

PHYSICIAN ID # _____________________________________________________

AN EQUAL OPPORTUNITY EMPLOYER
DUTY HOURS ATTESTATION

NOTICE TO HOUSESTAFF OFFICERS:

THIS FORM IS REQUIRED IN ORDER TO COMPLETE THE APPOINTMENT PROCESS PLEASE SIGN AND RETURN TO PHYSICIAN SERVICES.
Effective July 1, 2003 all residency programs in the United States must comply with the Accreditation Council for the Graduate Medical Education’s (ACGME) duty hours standards. This includes compliance with specialty specific duty hours language which limit housestaff officers duty hours to a maximum of 80 hours per week and impose other restrictions on duty hours. Residency programs that fail to comply with the duty hours and do not correct the deficiency are subject to adverse accreditation actions, including probation or withdrawal of accreditation. Programs that lose accreditation are virtually shut down and residents will not be able to complete ACGME accredited training required to be eligible for board certification examinations.

I attest that I viewed the SAFER (Sleep, Alteness and Fatigue Education in Residency) presentation and understand the implications of sleep deprivation.

I attest that I will comply with the ACGME duty hour standards and will immediately report any violations to the Office of Physician Services.

I agree to complete an anonymous survey to report duty hours and certify that my answers and all statements made by me are true and correct.

PRINT NAME: ____________________________  SIGNATURE: ____________________________
DEPARTMENT: ____________________________  DATE: ____________________________

General Duty Hours Standards:
- Residents are limited to a maximum of 80 duty hours per week, including in-house call, averaged over four weeks. In certain cases, starting in July 2004, residency programs will be allowed to increase duty hours by 10 percent if doing so is necessary for optimal resident education and the program receives approval from the appropriate RRC.
- Residents must be given one day out of seven free from all clinical and educational responsibilities, average over four weeks.
- Residents cannot be scheduled for in-house call more than once every three nights, average over four weeks.
- Duty periods cannot last for more than 24 hours, although residents may remain on duty for six additional hours to transfer patients, maintain continuity of care or participate in educational activities.
- Residents should be given at least 10 hours for rest and personal activities between daily duty periods and after in-house call.
- In-house moonlighting counts towards the weekly limit. In addition, program directors must ensure that external and internal moonlighting does not interfere with the resident’s achievements of the program’s educational goals and objectives.
I have received Section 458.345 and Section 458.331 of the Florida Statues and Chapter 64B8-6 of the Florida Administrative Code, which describe the laws and the rules that govern the Registration of the Interns/Residents/Fellows in the State of Florida.

I understand that it is my responsibility to read and be in compliance with these rules and regulations as they pertain to my professional practice.

I also understand that without the Department of Health, Florida Board of Medicine's issuance of an unlicensed physician registration number or a medical license I will not be able to start or continue my training program.

I further understand that registration with the Florida Board of Medicine automatically expires after two years without further action by the Board unless the Board approves an application for renewal.

It is my responsibility to obtain appropriate renewal of my unlicensed physician registration number.

Failure to renew the registration will result in dismissal from all clinical duties until the Board has approved such registration.

_________________________  ___________________________
Signature                      Date

_________________________  ___________________________
Print Name                     Department

Witness

RETURN THIS SIGNED AND WITNESSED FORM TO PHYSICIAN SERVICES
OBTAIN YOUR UM CANEID (C-NUMBER)
(Required for email accounts and access to electronic medical records.)

Name:_________________________      Program:_________________________

1- Go to the Create CaneID website
   https://caneid.miami.edu/createnewaccount.aspx

2- Enter your SSN and Date of Birth

3- Click continue

4- Enter in your information

5- Click continue

6- Write your new CaneID number below and submit with this packet:

   C___________________________
Applying for NPI Number

- You apply for the NPI number through their website: www.nppes.cms.hhs.gov/

- If you need assistance with your application you may contact NPPES @ 1-800-465-3203.

- Additional Information:
  - You must choose: Individual Provider
  - You are not a sole proprietor...
  - Your practice location: 1611 NW 12 Avenue Miami, FL 33136
  - Your business address and phone: Your individual service information; i.e. Medicine, Psychiatry, ETC.
  - You’re Taxonomy Code: Student Health Care
Cash Stipend

<table>
<thead>
<tr>
<th>Post Graduate Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$46,717.00</td>
</tr>
<tr>
<td>Year 2</td>
<td>$48,682.49</td>
</tr>
<tr>
<td>Year 3</td>
<td>$50,796.31</td>
</tr>
<tr>
<td>Year 4</td>
<td>$53,256.92</td>
</tr>
<tr>
<td>Year 5</td>
<td>$56,131.12</td>
</tr>
<tr>
<td>Year 6</td>
<td>$57,815.06</td>
</tr>
<tr>
<td>Year 7</td>
<td>$60,440.74</td>
</tr>
</tbody>
</table>

Pay Supplement: $50.00 bi-weekly

Please refer to Article 2; Section 1 of the Collective Bargaining Agreement regarding assigning Post Graduate levels.

I. Medical Insurance

(1) AvMed
   - 100% coverage
   - No premiums (for employee or dependents)

(2) Opt-Out Insurance
   - Deductibles: Single $750/ Family $1500
   - After deductibles is met hospital pays 75%, employee pays 25%

II. Dental Insurance - Humana Combenefits and no cost to employee and dependents

III. Mental Health Insurance - UM Behavioral Health for employee and dependents

IV. Disability Insurance - at no cost to employee while in training

V. Life Insurance - $50,000 at no cost to employee/ Supplemental Insurance $72/ year

VI. Professional Allowance - $1250/ yearly

VII. Parking - Discounted $5.54 bi-weekly

VIII. Lab Coats and Scrub - Three new lab coats and scrubs per academic year

IX. Meal Card - $1375 yearly

X. Vacation - 28 days per year including weekends and holidays

XI. Sick - 14 days

*** Note: Current union contract negotiations are in progress, salary, rates and benefits are subject to change.
Check List

AS SOON AS POSSIBLE:

☐ Return Original Welcome Packet to Physician Services
☐ Apply For License
☐ Complete Background Screening: https://www.tclogiq.com/jhhousestaff

30 DAYS PRIOR TO YOUR START DATE:

☐ Health Office Requirements
☐ Life Support Certification (a valid BLS certification is required prior to start date)
☐ NPI Number
☐ Go into Mandatory Orientation Schedule link located under the Welcome Packet link and print out your Mandatory Orientations
☐ Complete the following Electronic Medical Records Mandatory Online Training
   a. CERNER (JMH)
   b. Meditech (UMH)
   c. CPRS (VAMC)
   d. UChart (UMHC/SCCC)

10 DAYS PRIOR TO YOUR START DATE:

☐ Come to Physician Services (East Tower 1st Floor Room 1004) to pick up:
   - Physician ID #
   - Email address and computer log-in
   - Meal Card
   - ID Badge
   - Parking Access Form

☐ Lab Coats & Scrubs (Laundry Room- Basement DTC)
   - Pick up only Tuesday/Wednesday/Thursday 9am-12am & 1pm-3pm

☐ Rx Pads (Mental Health Building #1311 or West Wing Basement B-26 A)

BEFORE YOUR START DATE: (Check with your program coordinator if a training session has been scheduled for your department prior to contacting these offices)

☐ Hospital Information Technology System
   - Jackson IT (305) 585-6789
     o JMH PACS- (305) 585-7929
     o CERNER (305) 585-6761
   - UM IT (305) 243-5999
     o RIS PACS (305) 243-3665
     o CANE CARE (305) 243-2574