UW Medicine
UNIVERSITY OF WASHINGTON MEDICAL CENTER

Patient Care Services Credentialing at UW Medical Center

Attestation Application: YOUR APPLICATION WILL NOT BE APPROVED IF NOT COMPLETE

Step 1 - Your information, checklist of required documents & proposed role description

- Applicant full name.
- Applicant job title & employer organization.
- Contact phone & email. Please provide a reliable contact as well as a backup contact number, as you will be required to provide a copy of your file ***within 24 hours*** of our call or email**.**

I am responsible for:

☐ HIPAA training per employer.

☐ Immunizations per UWMC Employee Health and (CDC) guidelines:
Annually updated documentation of immunity to tuberculosis, measles, mumps, rubella, varicella, hepatitis B, pertussis. Proof of an initial COVID-19 vaccine series and a bivalent booster administered after 9/2022. Call (206) 598-4848 with specific questions.

☐ Annually updated confidentiality form, attached.

☐ Photo ID Worn While at UWMC:

For UW/UW entity personnel (e.g. Harborview, Valley Medical Center, Airlift NW, UW School of Medicine departments, UW School of Pharmacy, UW School of Public Health, and colleagues at Fred Hutch Cancer Center), upon approval you will wear the photo ID badge issued by your employer. Photo ID is to be worn at all times in the Medical Center.

OR

☐ **For Non-UW/UWM entity personnel** (e.g. Puget Sound Blood Center, Kaiser, Seattle Children's, VA, Puget Sound Health Care System), upon approval you will obtain a UWMC photo ID badge from Public Safety. Photo ID is to be worn at all times in the Medical Center.
Contact with Public Safety with specific questions by calling (206) 598-4909.

☐ A background check is required for all non-UW/UWM entity personnel. Complete the Criminal Background Authorization attached.

My proposed role at UWMC:

RESEARCH.

CLINICAL PRACTICE.

LICENSURE:
If proposed role requires licensure then you must have record of current licensure or certification with the State of Washington.
Note: Medical Assistant - phlebotomist is required by law for venipuncture.
Washington State Health Medical Assistants

My proposed role requires CURRENT LICENSURE with the State of Washington.

License type

License number

Expiration

ROLE ACTIVITIES.

Research non-clinical: recruit patients, obtain consent, administrate surveys, interview patients, data/record review, chart in patient record.

Other activities with patients: including physical assessment, culture swab, etc. Please specify.

Clinical practice:

Blood draw.

Venous: from central venous access, peripheral venous access, venipuncture.

Arterial: from indwelling line, arterial puncture.

Invasive procedures (describe).

Medication administration (list meds).

Other (describe).

Work Area When On-site at UWMC:

7S General Clinical Research Center.

Other areas (please specify).

Step 2 - Your manager's information & signature

Required Signature:
I attest that the applicant is competent to perform the proposed role as described.

I understand that I may need to produce a copy of the documentation above ***within 24 hours*** upon request by University of Washington Medical Center, Patient Care Services Administration.

Access to Patient Records:

If access to electronic medical records is applicable to the applicant's role, it is my responsibility as Manager to contact the UW Medicine Online Information Portal.

Employee Manager:
Print full name

Signature & date

Organization/Phone/Email

Step 3 - Your signature

Required Signature:
I attest to the truth and accuracy of the information provided. I understand that my file may be audited and that I may be required to provide proof of HIPAA training, immunization records, a signed confidentiality agreement and proof of current licensure ***within 24 hours*** upon request by University of Washington Medical Center, Patient Care Services Administration.

Signature & date

Step 4 - Submission of application & retention of records

Email as PDF attachments ONLY the signed *Attestation Application, Criminal Background Authorization Form* (if applicable) and **A COPY OF YOUR COVID-19 VACCINATION CARD** to University of Washington Medical Center, Patient Care Services Administration. Paper applications and incomplete applications will NOT be accepted.
Please allow at least 2 weeks for processing.

Retain these records in your employee file. ***You are responsible for maintaining and keeping these records current***. Your file may be audited and a copy must be provided to University of Washington Medical Center, Patient Care Services Administration ***within 24 hours*** of our call or email**.**

UW Medicine

Non-UW Medicine Workforce Privacy, Confidentiality and Information Security Agreement

Access to UW Medicine Electronic Medical Record (EMR) systems is permitted to authorized users to view protected health information (PHI) electronically. Access is provided only to individuals whose access has been approved by a UW Medicine Administrator, Director or under a Business Associate Agreement.

A. Non-UW Medicine Workforce Information:

Name_____

Organization_____

Address_____

City, State, ZIP _____

Phone number_____ **Fax:**_____

Email _____

B. Privacy, Confidentiality, and Information Security Acknowledgement

UW Medicine has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their protected health information (PHI). Federal and state laws and regulations govern the privacy of our patients and their health information.
In the execution of services by the organization, I will or may see patients with a variety of medical issues and/or may see and hear confidential information relating to these patients. This relates to information past, present and future physical or mental health or condition of an individual.
As a condition of accessing UW Medicine PHI, I understand and agree that:

- I will comply with federal and state statutory and regulatory requirements (including 45 CFR Parts 160 and 164 (HIPAA) and RCW 70.02).
- I agree to safeguard my UW Medicine access account, and password. I will not share my password with any other person and will not permit others to access the UW Medicine systems through my account. I understand that I will be held accountable for all accesses made under my login and password and any activities associated with the use of my access privileges.
- I will log out or lock computer sessions prior to leaving a computer.
- I understand that I am being given access to PHI and that my access will only occur according to the contract or agreement signed by UW Medicine and the company or healthcare entity I represent or in accordance with my role as a government investigator, auditor or site reviewer. The information disclosed under this agreement will be only used for the purpose(s) described in that contract, agreement or as needed for the investigation, audit or site review.
- I understand that my access will be monitored to assure appropriate use.
    - I understand that the Secretary of the Department of Health and Human Services or the Washington State Attorney General may investigate complaints and may seek criminal prosecution or impose civil monetary penalties to my company and/or me for inappropriate uses or disclosures of certain protected health information.
- I will limit my access, use, and disclosure of patient information to the minimum amount necessary to perform my authorized activity or duty. I understand that the patient information I access is confidential and will not copy or disseminate except as authorized or allowed or required by law. I will only discuss patient, confidential, or restricted information only with those who have a need-to-know and the authority to receive the information.
    - I will keep protected information taken off-site fully secured and in my physical possession during transit, never leaving it unattended or in any mode of transport (even if the mode of transport is locked). I will only take protected information off-site if accessing it remotely is not a viable option.
    - I will store all protected health information on secured systems, encrypted mobile devices, or other secure media.
    - I agree that if I terminate my position with my company or no longer work in my current position, or otherwise am no longer functioning in the role under which access was granted, I, or my company, will immediately notify UW Medicine IT Services Help Desk at 206-543-7012 or email mcsos@uw.edu and request that my access be deactivated.
- I agree to abide by this agreement and understand that these are privileges granted by UW Medicine to me. I further understand and acknowledge that UW Medicine may terminate this privilege at any time.
    - I will report all concerns about inappropriate access, use or disclosure of protected information, and suspected policy violations to UW Medicine Compliance (206-543-3098 or comply@uw.edu).

_____ _____

Signature **Date**

C. Agreement to be retained by the non-UW Medicine access coordinator

I understand that I will be responsible for this individual when they are accessing PHI and acknowledge that their access to PHI is in compliance with UW Medicine Privacy Policies.

*Name:*_____ *Signature*_____

*Title:*_____ *Phone number:*_____ *Date:*_____

Retain for six (6) years

UWMedicine

CRIMINAL BACKGROUND AUTHORIZATION

Instructions for completing this form on reverse side.

UWMC - MONTLAKE
1959 NE Pacific Street
Seattle, WA 98195

SECTION 1. AGENCY INFORMATION (COMPLTETED BY CONTRACTOR)		
1. NAME (TRADE NAME) OF HOSPITAL UW MEDICAL CENTER - MONTLAKE		2. THE LOCATION (STREET) ADDRESS 1959 NE Pacific Street | Seattle WA 98195
3. HOSPITAL PHONE 206.598.4909	3a. HOSPITAL FAX NUMBER 206.598.2800	4. HOSPITAL EMAIL hospsec@uw.edu

SECTION 2. ALL QUESTIONS IN THIS SECTION MUST BE COMPLETED BY THE APPLICANT (PERSON TO BE CHECKED)			
5. SOCIAL SECURITY NUMBER	6. DATE OF BIRTH	7. GENDER	8. RACE (OPTIONAL)

CURRENT LEGAL NAME	OTHER NAMES YOU HAVE BEEN KNOWN BY
9. LAST NAME	12. BIRTH NAME LAST FIRST FULL MIDDLE NAME
10. FIRST NAME	13. OTHER MARRIED OR LEGAL NAME(S) (OR WRITE NONE) LAST FIRST FULL MIDDLE NAME
11. FULL MIDDLE (OR WRITE NONE)	14. NICKNAME(S)/OTHER KNOWN NAME(S) (OR WRITE NONE)

15. HOME ADDRESS	APT/UNIT	CITY	STATE/ZIP

16. HAVE YOU EVER BEEN CONVICTED OF, OR DO YOU HAVE CHARGES PENDING FOR ANY CRIME? · YES · NO
If yes, give the crime, the conviction date or charge status and the state where it occurred.
Note, this includes all convictions and charges:

_____

17. HAVE YOU EVER BEEN FOUND TO HAVE SEXUALLY ABUSED, PHYSICALLY ABUSED, NEGLECTED, ABANDONED OR EXPLOITED A CHILD OR ADULT? · YES · NO
If yes, give name of court, state licensing board, displinary board, or dependency action, details of the finding, and state where it occurred:

_____

18. HAVE YOU EVER HAD A CONTRACT AND/OR LICENSE TO CARE FOR CHILDREN OR ADULTS DENIED, TERMINATED, REVOKED, OR SUSPENDED? · YES · NO
If yes, give date, contract and/or license type, name of contracting and/or licensing agency, and the state where it occurred:

_____

19. HAS A COURT EVER ISSUED AN ORDER OF PROTECTION AGAINST YOU FOR ABUSE, NEGLECT, FINANCIAL EXPLOITATION, or ABANDONMENT? · YES · NO
If yes, give date, court, and the state where it occurred:

_____

20. DRIVER LICENSE OR STATE IDENTIFICATION NUMBER
Number:_____State:_____

21. LENGTH OF TIME LIVED IN WASHINGTON STATE
Years:_____Months:_____

22. I understand that this authorization form and the background check is the result of Washington State Laws and Regulations and if any of the information provided above is found to be false, it may result in the loss of my employment/contract.

I understand that I am signing this under penalty of perjury. By signing this form, I state that the information above is true and correct to the best of my knowledge. I understand untruthful or misleading answers, or deliberate omissions are cause for denial or immediate termination of my employment/contract. My signature below authorizes UW Medicine to obtain now and on a periodic basis conviction records from Washington State including Washington State Patrol and other states; and to obtain from Washington and other states licensing information and any determination or finding of abuse, neglect, exploitation or abandonment. l understand that the result of this background check(s}will be released to the agency, the facility or my employer/contractor named above. I understand I may contact UW Medicine to receive a copy of my WSP record, ten (10) days after signing this form.

23. SIGNATURE OF PERSON TO HAVE BACKGROUND CHECK 24. DATE SIGNED

_____ _____

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

This form will be returned if any portion of the required information necessary to conduct a background check is not entered or is not legible.

SECTION 2:
To be completed by the applicant (person to be checked).

1. Completed by UWMC
2. Completed by UWMC
3. Completed by UWMC

3a. Completed by UWMC

4. Completed by UWMC
5. Required.
6. Required.
7. Required.
8. Optional.
9. Required.
10. Required.
11. Required.
12. Required. Must include complete name at birth. If same as #9 - #11, must write SAME.
13. Required. Must list all married names used (male or female); must write NONE if none.
14. Required. Must list all nicknames used (male or female); must write NONE if none.
15. Required.
16. Required.
17. Required.
18. Required.
19. Required.
20. Required. Must list driver lic. number or state ID number; must write NONE if none.
21. Required. Indicate number of consecutive years and/or months lived in WA State.
22. Read prior to moving to block #23.
23. Required signature of applicant.
24. Required. Date signed by applicant.