CHILDREN'S HOSPITAL LOS ANGELES

Academic Affairs-GME Office - MS #71, Ext. 15584

GME Trainee Clearance

GME Rotators

➔*FORMS must be TYPED or using a computer. Signatures in **black** ink, please!*

FULL NAME:
First Name - Middle Initial -Last Name - TITLE: MD/DO/DDS/DMD

Social Security Number: _____

Employer/Home Institution - Name - City, State - Country

_____

☐ Rotating Resident ☐ Rotating Fellow PL- PGY-
Training Status (Check One) Program Level Postgraduate Year

For CHLA Internal use only

CHLA – Division/Program: PEDIATRIC SURGERY

Program Coordinator: JANE LEE

eMail: JANELEE_____@chla.usc.edu Ext 000013644

Dates approved for Rotation: FROM: _____ TO: _____

NOTES:
-ID#: Nonemployee and NPI

CHLA Clearance – *Information/credentials verified by CHLA:*

Employee Health Services (EHS): X_____
Ext. 12533, 4601 Sunset Blvd. Signature----------Stamp Date

☐TB test ☐Chest XR ---- RESULTS dated: _____ Valid through: _____
(Dates to cover rotation term)

Academic Affairs - GME Office:
Ext. 15584, Duque Bldg. X_____
Signature----------Stamp Date

➔ Rotators: ID#/*Parking cards-ID badges will be issued after clearance from Employee Health (EHS) and Academic Affairs, GME Office, with ID#*

Parking Office: X_____
Ext.12214, 4601 Sunset Blvd. Signature----------Stamp Date
Non-Employee (HR) ID # _____

Medical Records (HIM): X_____
-for Medical Records privileges, *if applicable* Signature----------Stamp Date
Ext, 17606, Duque Bldg. Ground flr.
Provider ID # _____

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➔*FORMS must be TYPED or using a computer. Signatures in black ink, please!*

CHILDREN'S HOSPITAL LOS ANGELES

GME REGISTRATION FOR ROTATIONS

*TRAINEE **PERSONAL** INFORMATION*

FULL NAME: **NPI #**____

First Name - Middle Initial -Last Name - MD-DO-DDS-DMD

SSN required--ATTACH COPY #: _____ Date of birth: Gender: Race-Ethnicity: _____

White – Black – African American – Hispanic – Asian – Native American – American Indian – Alaskan Native – Pakistani --- ☐ Decline to State

Veteran ☐ ☐US Citizen ☐Other Citizenship: Country: ☐INS VISA or Resident CARD-ATTACH COPY - Expires:

Local or Permanent address: Street/City/State/ZipCode:

Phone: Work E-Mail:

GRADUATE EDUCATION and LICENSURE

Graduate School – Attach copy diploma - translation Graduation date: _____

Name of School /City/State/Country: _____

California License. Attach copy: License #: _____ State: **CA** - Issue date: _____ -Expires: _____

- ❑ No CA License: Attach Statement signed by CHLA Program Director and by Rotating Trainee.
- ❑ FMG Unlicensed PL1,2,3: Attach current PTAL Postgraduate Training Authorization Letter from Medical Board of CA.
- ❑ FMG Foreign Medical Graduate: ATTACH COPY - ECFMG Certificate # _____ Issued on: _____

POST-GRADUATE TRAINING

Affiliate/Employer/Sponsoring Institution: NAME/City/State: _____

☐ Rotating Resident ☐ Rotating Fellow Program Level PL- Postgraduate Year PGY-

Current Residency-Fellowship Program ☐ ACGME Approved –Current Specialty: _____

Internship Program-Initial Postgrad Program-Initial Specialty: _____ Internship Start Date: _____

TRAINEE – *My signature is confirmation that the information I have provided is accurate and complete to the best of my knowledge:* Trainee Signature: X Date: _____

For CHLA Internal use only

❑ Malpractice Insurance: ❑ Yes - CHLA CC #_____(For County only)

❑ No-Attach Certificate of Insurance, or letter with statement of coverage.

❑ Stipend: __Yes: CC #_____ __No. Paid by Employer

CHLA DIVISION/PROGRAM: PEDIATRIC SURGERY

Program Coordinator: JANE LEE E-Mail: JANELEE@chla.usc.edu Phone: (323) 361-3644

Dates Approved for Rotation: FROM: _____ TO: _____ Days per week: __ Months per year: __

Program Director (or Delegate): EVELINE SHUE, MD

CHLA Program Director Approval – Signature: X Date: _____

ATTACHMENTS:

- ☐ Registration form
  - ☐ Immunization Records. Flu vaccine during flu season Nov 1-Mar 31
- ☐ Social Security (SS) card – or W2 as proof of SSN
- ☐ School diploma – with translation if not in English
  - ☐ ECFMG if foreign medical graduate (IMG)
- ☐ License – or Unlicensed Statement
  - ☐ PTAL if unlicensed foreign medical graduate
- ☐ PLA Program Letter of Agreement, current – On file
- ☐ Rotation letter, or *Application for Rotations*, from Affiliate.
- ☐ Master Rotation schedule from Affiliate for current FY
- ☐ Professional Liability (malpractice) Certificate of Insurance
- ☐ Postgraduate Training Verification form
- ☐ Curriculum Vitae – CV current as of rotation start date
- ☐ Forms (3):
  - ☐ Role in Environment – ☐Sedation Requirements – and
  - ☐ Confidentiality Statement
- ☐ HIPAA Certificate, or
- ☐ CHLA manual test **--HIPAA Date:** _____

APPLICATION FOR ROTATIONS at
CHILDREN'S HOSPITAL LOS ANGELES for
Affiliated Rotating RESIDENTS & FELLOWS (ROTATORS)

➔ *Use in lieu of a Rotation letter from Affiliate* ←

➢ Section 1- **To be completed by** Trainee's Home **Institution/Employer**:

_____

Trainee Full Name Home Institution Name

The above named Trainee is a -year ☐ Resident ☐ Clinical Fellow in good standing in the Program of _____,

Department of _____. The trainee is authorized to participate in the elective rotation at CHLA in the

Training Program of _____ for the DATES as follow:

FROM: TO:

Home Institution Signatures: (*Signatures in black ink)*

Program Director/Division Head/Chair: X_____ Date: _____

Name (print or type): _____

Institution Name: _____

Address _____

Home Institution Program coordinator/contact person: _____

E-mail Address: _____ Phone number:

NOTE: *The following does not apply to L.A.County Trainees:*

Professional Liability: The above-named Resident/Clinical Fellow is currently covered and shall continue to be covered by **malpractice insurance provided by** his/her **home institution/**employer while participating in clinical rotations at CHILDREN'S HOSPITAL LOS ANGELES (CHLA). Attached to this application form is a **signed Certificate of Malpractice Insurance**, or a **Liability Letter, identifying the insurance carrier**. If such **insurance is cancelled** or otherwise found to be inadequate, it shall result in the **immediate termination** or **suspension of rotation.**

➢ Section 2- **To be completed by CHLA Program/Department:**

The above named ☒ Resident ☐ Clinical Fellow (check one) would like to apply for an approved Rotation in the CHLA Training Program of PEDIATRIC SURGERY_____, CHLA Department of SURGERY_____, for the period DATES as authorized above by Employer/Home Institution.

CHLA Signatures: *(Signatures in black ink)*

CHLA Program Director/Division Head/Chair: X_____ Date: _____

Name (print or type): EVELINE SHUE

CHLA Program coordinator/contact person: JANE LEE

E-mail Address: JANELEE_____@chla.usc.edu

Phone number: 323-361-3644

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CHILDREN'S HOSPITAL LOS ANGELES

California Medical License

Unlicensed Rotating Trainees

This form must be completed prior to a **rotation** *of a Physician without a valid* ***California*** *license, and signed/dated by* rotating *Trainee and by CHLA division head, program director, or authorized designee.*

If the rotating resident or rotating fellow (Medical/Dental Trainee) does NOT have a **California** medical/dental license, please check off the reason from the following list:

☐ **For US Medical/DO/Dental school graduate**:
Trainee has less than 24 months of training post-Medical/Osteopathic/Dental School, in any training program, regardless of specialty or geographic location, either within California or anywhere in the US.

☐ **For International/Foreign medical school graduate (FMG)**:
Trainee has less than 36 months of postgraduate training in an accredited program in the US, regardless of specialty or geographic location, either within California or anywhere in the US.

- ☐ Attach current, dated, signed Postgraduate Training Authorization Letter (PTAL) issued by the Medical Board of California (MBC).

☐ **For rotators from out-of-state**:
The cumulative postgraduate medical training time in **California**, which includes the time at CHLA, will be **less than 3 months**.

☐ **Other**: medical (please explain): ____

An unlicensed medical Trainee may NOT begin a rotation at CHLA without this form filled out, signed by Trainee and approved by the CHLA program director, or authorized designee.

_____
Print Name of Trainee

EVELINE SHUE
Print Name/Title-CHLA Staff
Division Head / Program Director / Designee

X_____
SIGNATURE: *Use black ink*.- Trainee

_____
Date

X_____
SIGNATURE: *Use black ink*- CHLA Approval

_____
Date

Unlicensed Rotators:
Submit completed form with Trainee packet to Academic Affairs Office-GME

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CHILDREN'S HOSPITAL LOS ANGELES

GME POST-GRADUATE TRAINING VERIFICATION

FULL NAME:	
SOCIAL SECURITY NUMBER:	
MEDICAL/DENTAL SCHOOL:	GRADUATION DATE:
ECFMG # (IF APPLICABLE)	ECFMG CERTIFICATE DATE:
BOARD CERTIFICATION	CERTIFICATION DATE:
LICENSURE # (NAME ALL STATES): License #	LICENSE issue DATE:

INCLUSIVE DATES OF TRAINING:

TYPE OF TRAINING	DATES OF TRAINING (NEED MONTH & YEAR):		SPONSORING INSTITUTION:	SPECIALTY:
INTERNSHIPS:	FROM:	TO:		
	FROM:	TO:		
RESIDENCIES:	FROM:	TO:		
	FROM:	TO:		
	FROM:	TO:		
	FROM:	TO:		
FELLOWSHIPS:	FROM:	TO:		
	FROM:	TO:		
	FROM:	TO:		

OTHER TRAINING EXPERIENCE FROM PERIOD OF TIME FOLLOWING GRADUATION FROM MEDICAL SCHOOL, DENTAL SCHOOL, ECFMG CERTIFICATE DATE, ETC. NOT ACCOUNTED FOR ABOVE:

TYPE OF TRAINING	DATES OF TRAINING (NEED MONTH & YEAR):		SPONSORING INSTITUTION:	SPECIALTY:
	FROM:	TO:		
	FROM:	TO:		
	FROM:	TO:		

The information that I have provided is accurate and complete to the best of my knowledge. I AUTHORIZE the release of supporting documentation from my sponsoring institution to validate the information provided above.

SIGNATURE OF TRAINEE: *Use black ink:* X DATE:_____

NAME OF SPONSORING INSTITUTION: *(Not CHLA)*

CONTACT AT SPONSORING INSTITUTION:	E-MAIL ADDRESS:
	PHONE NUMBER:

FOR HOSPITAL OR CENTRAL PROGRAM INSTITUTIONAL OFFICER:

THE ABOVE QUALIFYING CREDENTIALS HAVE BEEN VERIFIED BY OUR PROGRAM IN ACCORDANCE with THE JOINT COMMISSION (TJC) STANDARDS on the ACCREDITATION OF HOSPITAL ORGANIZATIONS.

NAME OF CERTIFYING OFFICIAL:	SIGNATURE: X
TITLE OF CERTIFYING OFFICIAL:	DATE:

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CHILDREN'S HOSPITAL LOS ANGELES

Trainee Role in ENVIRONMENT of CARE

➔ *Please **keep this information,** and **sign** and return the enclosed statement indicating that you have read and understand your role in the safety, security, and environment of care at Children's Hospital Los Angeles.*

Codes Overhead Page-Ext. 33

- Code **Red** – Fire – Ext 33
- Code **Blue** - Medical Emergency – Ext 33
- Code **Orange** –Hazardous material spill – Ext 33
- Code **Pink** – Infant Abduction – Ext 711
- Code **Purple** – Child Abduction – Ext 711
- Code **Yellow** – Bomb Threat – Ext 711
- Code **Gray** – Combative Person – Ext 711
- Code **Silver** – Armed Individual/Active shooting/ /Hostage situation – Ext 711

Identification Badges

- Your CHLA ID badge must be worn at all times when on the CHLA premises
- Your ID badge must be worn on the upper body with the photo and name facing outward.
- If you loose your ID, you must report it missing to Security (Ext. 1-2313) and the Parking Office (Ext. 1-2214).

Visitor Badges

- All visitors to CHLA (whether parents, guardians families, vendors, etc.) must have a visible ID badge on their person
- Visitor badges are as follows:
  - Yellow Badge – visitors to inpatient care areas.
  - Orange Badge – visitors to outpatient clinics, labs, and the Emergency Dept.
  - Blue Badge – Visitors to general/non-patient care areas.

Wrong Badge or No Badge

- All Medical Staff, House Staff, and pre- & post-doctoral fellows and employees are responsible for:
  - Escorting visitors without badges to the Guest Services Desk at the main entrance, or calling Security.
  - Asking if you can assist a visitor with the wrong badge who is in the wrong area. Example: Visitor with a blue badge is seen in an inpatient care area.

Safety

- Know location of the Safety Manual.
- Know how to complete a Patient/Visitor Event Report in the event something unusual happens to you or your patient.

Hazardous Materials/Waste

- Wear proper protective gear.
- Inquire regarding proper disposal of chemicals.
- Require labels on all chemicals that are used by you.
- Know where the MSDS for chemicals in your area are located.

Fire/Life Safety

- Rescue endangered patients. Close doors.
- Activate the alarm system.
- Call Ext. 33 to report fire.
- Contain and/or Extinguish the fire.
- Know where the fire alarm & fire extinguishers are located.
- Know that the hospital has a series of smoke compartments designed to prevent the spread of smoke and fire.
- Know that you may be needed to help transfer patients to another area.
- Evacuate if danger of smoke or fire spread.

Fire Extinguisher Use – PASS

- P - Pull the pin
- A - Aim the hose/extinguisher
- S - Squeeze the handle
- S - Sweep the base of the fire

Evacuation Procedure

- Move horizontally beyond next fire/smoke door.
- Move vertically, two floors minimum or unit capable of receiving patient type.
- Meet at designated assembly area.
- Account for all staff and patients.
- Notify emergency operations center Ext. 1-2342 of status/missing persons.
- Patient Priority – those closest to danger, ambulatory, those you can move yourself, those you need help to move.

Emergency Preparedness/Disaster Procedure

- Code Orange will be announced overhead.
- All available physicians report to the Personnel Pool.

Medical Equipment Malfunction

- Remove from service and sequester any medical equipment you suspect or know was involved in a patient incident notify Risk Management immediately.
- Assure that all equipment is reviewed by the Biomedical Dept. before it is used in patient care.

Utilities Failure

- Know that the Hospital's emergency power generators will start in less than 10 seconds.
- Know that these power supply systems are tested on a weekly basis.
- You may be needed to assist patients whose equipment has failed.
- Know process to follow in event of utilization failure.

CHILDREN'S HOSPITAL LOS ANGELES

Trainee ROLE in ENVIRONMENT of CARE

I have been oriented to the following information on the Trainee Role in Environment of Care:

- **Codes**
- **Security Badges**
- **Visitor Badges**
- **Wrong Badge or No Badge**
- **Safety Management**
- **Hazardous Materials/Waste Management**
- **Fire/Life Safety Management**
- **Fire Extinguisher Use – PASS**
- **Evacuation Procedure**
- **Emergency Preparedness Management**
- **Medical Equipment Management**
- **Utilities Management**

Trainee - Signature X

*(Signature in **black** ink)*

Print Name (first-middle-last)

Date (month/date/year)

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CHILDREN'S HOSPITAL LOS ANGELES

SEDATION REQUIREMENTS

- Whether you are a fellow or a rotating resident, or a member of the Medical Staff, you must have specific privileges to give sedation, including writing orders for sedation.

- *If* you wish to have this privilege, the Medical Staff Office can provide you with the self-learning module for sedation. It takes about an hour to go through the material, and then you must pass an examination. In addition, you must have a current BLS, PALS, or ACLS card.

- *If* you write orders for sedation and do not have the privilege to do so, you put yourself and the Hospital in legal jeopardy.

I have read and understand the above:

Trainee - Signature X

*(Signature in **black** ink)*

Print Name (first-middle-last)

Date (month-date-year)

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CHILDREN'S HOSPITAL LOS ANGELES
POLICY AND PROCEDURE MANUAL

NUMBER		
		ETH-1.0
EFFECTIVE	DATE REPLACES	PAGE
9/6/06	1/13/03	1 of 2

SUBJECT
CONFIDENTIALITY OF INFORMATION

APPROVED BY

STATEMENT

In order to protect the confidentiality of patient care and hospital matters, Children's Hospital Los Angeles considers all information regarding its patients, their families, Hospital employees and hospital business as confidential. All board members, officers, employees, volunteers, residents/fellows, and students, are required to adhere to this policy and not release or disclose any information without appropriate written authorization. The Hospital complies with all applicable federal (HIPAA) and state law regarding the release and protection of health information.

Board members, officers, employees, volunteers, residents/fellows, and students are asked to sign a statement of confidentiality when they begin their tenure with Children's Hospital Los Angeles to acknowledge their awareness of and reaffirm their commitment to this policy.

This policy includes the confidentiality of medical staff records and procedures, all protected health information, employee personnel files, and information contained in the Hospital computer systems, including the clinical information system (hereinafter referred to as KIDS and/or any other clinical system requiring a password) for Medical Staff and medical training staff. Regarding KIDS, each provider/clinician is required to use their assigned unique username also called sign-on access to the KIDS system. In addition, passwords and sign-ons must not be shared. KIDS passwords and sign-ons will be assigned only when all paperwork has been submitted, clearance has been given, a provider number assigned, and training on the KIDS systems has been successfully completed.

Board members, officers, employees, volunteers, residents/fellows, and students are also asked to refrain from discussing any patient information or Hospital business in any inappropriate area, including corridors, elevators, the cafeteria, McDonalds, Hospital lobbies, or waiting rooms.

All areas within the Hospital campus shall ensure that patient identifying information and diagnosis are not available to the public through any device, mechanism or process.

Author: Michael Robin

REVIEW DATES
3/97, 12/97, 8/99, 8/02, 09/06

CHILDREN'S HOSPITAL LOS ANGELES

CONFIDENTIALITY STATEMENT OF ACKNOWLEDGEMENT

STATEMENT

In order to protect the confidentiality of patient care and Hospital matters, Children's Hospital Los Angeles considers all information regarding its patients, their families, Hospital employees and Hospital business as confidential. All board members, officers, employees, volunteers, residents/fellows, and students are required to adhere to this policy and not release or disclose any information without appropriate written authorization. The Hospital complies with all applicable federal (HIPAA) and state law regarding the release of protected health information.

This policy includes the confidentiality of medical staff records and procedures, all patient information, employee personnel files and information contained in the Hospital computer systems, including the clinical information system (hereinafter referred to as KIDS and/or any other clinical system requiring a password) for Medical Staff and medical training staff. Regarding KIDS, each provider/clinician is required to use their assigned unique username also called sign-on access to the KIDS system. In addition, passwords and sign-ons shall not be shared. KIDS passwords and sign-ons will be assigned only when all paperwork has been submitted, clearance has been given, a provider number assigned, and training on the KIDS systems has been successfully completed.

Board members, officers, employees, volunteers, residents/fellows, and students are also asked to refrain from discussing any patient information or Hospital business in public areas, including corridors, elevators, the cafeteria, McDonalds, Hospital lobbies or waiting rooms.

ACKNOWLEDGEMENT:

NAME-Please Print: _____, I have read and agree to comply with the Children's Hospital Los Angeles, Confidentiality Policy. I understand that I am prohibited from divulging any information regarding patients, their families; employees; or matters related to Hospital business except as mandated by hospital policy and/or law; or sharing of KIDS passwords and sign-ons.

Trainee - Signature X_____ Date
*(Signature in **black** ink)*

09/06

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→ *Take Course and Test in lieu of HIPAA Certificate*

CHILDREN'S HOSPITAL LOS ANGELES

HIPAA

Health Information Portability and Accountability Act (HIPAA)
Privacy Regulations, effective April 14, 2003
COURSE

Primary Goals of the HIPAA Legislation:

- Assure health insurance portability
- Reduce healthcare fraud and abuse
- Simplify electronic administrative processes
- Guarantee security and privacy of health information

HIPAA is the most sweeping legislation to affect healthcare since Medicare in 1965. Nearly everyone will be affected: payors, employers, providers, clearinghouses, practice management system vendors, billing agents, and service organizations. In regard to protecting patient information, **security is defined as the protection of information, data and systems from accidental or intentional access by unauthorized users. Common threats to patient information security include talking about patients, using identifiable information such as names, diagnosis, etc., in public areas.**

Examples of Protected Health Information:

- Clinical information
- Name/social security numbers
- Name of relatives/family name/employer
- Health plan numbers/account numbers
- Telephone numbers/fax numbers/e-mails
- All dates related to the individual—birth, service
- Geographic subdivision smaller than state
- Any information that can reasonably identify a patient

Penalties for Non-compliance With HIPAA Regulations:

Monetary Penalty	Term of Imprisonment	Offense
$100	N/A	Single violation of a provision
Up to $25,000	N/A	Multiple violations of an identical requirement for prohibition made during a calendar year
Up to $50,000	Up to one-year	Wrongful disclosure of individually identifiable health information
Up to $100,000	Up to five years	Wrongful disclosure of individually identifiable health information committed under false pretenses
Up to $250,000	Up to 10 years	Wrongful disclosure of individually identifiable health information committed under false pretenses with intent to sell, transfer, or use for commercial advantage, personal gain, or malicious harm.

Failure to implement transaction sets can result in fines of $225,000 per year or more **($25,000 per requirement, times nine transactions)**

Failure to implement privacy and security measures can result in imprisonment.

Patient Rights:

- Patients have the right to:
  - Look at and obtain a copy of their health information.
  - Know how their health information has been used and to whom it has been disclosed.
  - File a formal compliant if their privacy has been violated.
  - Patient or parental consent must be obtained before a patient's health information can be released to family members.
  - Protecting patient information includes all forms of communication – electronic, written and verbal.

•**Notice of Privacy Practices:**

- Covered Entities must provide a simple explanation of their privacy practices. Direct treatment providers must make a good faith effort to obtain written acknowledgment of receipt of the notice of privacy practices.

•**Authorization:**

- All Covered Entities must obtain individual authorization for each use or disclosure of treatment, payment or health care operations (PHI) for non-TPO activities.

•**Minimum Necessary:**

- Employees should use only the information minimally necessary to do their job.

•**Business Associates:**

- Covered Entities may disclose PHI to business associates. They are required to have contracts that require their Business Associates to observe certain privacy standards listed in the Regulations.

•**Personal Representatives (Parents):**

- HIPAA gives control of a minor's PHI to the parent, guardian, or person acting in *loco parentis* with certain exceptions.
- HIPAA does not overturn state laws that give providers discretion to disclose PHI to parents or prohibit the disclosure of PHI to a parent.
- Verification of the personal representative's identity is a critical overlap with physical security.

•**Health-related Communications and Marketing:**

- Marketing activities using PHI require authorization from each person for each use of their PHI.

•**Research:**

- PHI may not be used or disclosed for research without the standard written HIPAA authorization or a waiver of authorization approved by the Committee on Clinical Investigations.

PRIVACY DOs

- Immediately remove all patient health information from printers, fax machines and photocopiers.
- Dispose of protected health information in the appropriate confidential bin.
- When conducting a conversation regarding a patient, do so in a private place or speak quietly so you can't be overheard.
- Keep medical records and other documents containing personal health information out of public view.
- When possible, close patient/examining room doors or draw curtains and speak softly when discussing patients' health information.
- Treat other people's confidential information as if it were your own.
- Password-protect your laptop computer and your personal digital assistant (pda).
- Report privacy violations in the Hospital to the Privacy Officer, at Extension 12302, so we can improve our organization's privacy practices.

PRIVACY DON'Ts

- Don't share confidential patient information with anyone who doesn't need to know it to do his or her job.
- Don't share passwords on your computer.
- Never access information about a patient unless you need it to do your job.
- Don't walk away from open medical records, lab results, or computers etc. Close records first and use a bookmark, if necessary.

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→ ***In lieu of HIPAA Certificate, Take Course and Test***

CHILDREN'S HOSPITAL LOS ANGELES

HIPAA
COMPETENCY TEST

1. Which of the following statements about confidentiality and protecting patient information are true?

   ☐ Only authorized people are allowed to look at or use patient information
   ☐ Any health information that can identify a person must be treated as confidential
   ☐ Confidential information should be shared only with those who have the "need to know"
   ☐ All of the above

2. In regards to protecting patient information, security is defined as:
   ☐ The requirement that all patient information either be under lock and key or protected by security officers
   ☐ The protection of information, data and systems from accidental or intentional access by unauthorized users
   ☐ None of the above
   ☐ All of the above

3. Which of the following standards require health care organizations to protect patient information?
   ☐ Chain of Trust (COT)
   ☐ Prospective Payment System (PPS)
   ☐ Health Information Portability and Accountability Act (HIPAA)
   ☐ Outcomes Assessment Information Set (OASIS)

4. Organizations that violate patient privacy and security standards can suffer penalties such as:
   ☐ Fines, possibly in the thousands of dollars
   ☐ Imprisonment
   ☐ Bad public relations
   ☐ All of the above

5. Common threats to patient information security include:
   ☐ Talking about patients, using identifiable information such as names, diagnosis, etc., in public areas
   ☐ Logging off the computer when finished
   ☐ Maintaining patient listings and other information out of the view of unauthorized people
   ☐ All of the above

HIPAA Competency Test

6. Patients have the right to:
   - ☐ Look at and obtain a copy of their health information
   - ☐ Know how their health information has been used and to whom it has been disclosed
   - ☐ File a formal complaint if their privacy has been violated
   - ☐ All of the above

7. Protected health information (PHI) is any information that can identify a patient.
   - ☐ True
   - ☐ False

8. Talking about a patient's condition or diagnosis, while in a public area, would be a violation of patient privacy even if the patient's name were not mentioned.
   - ☐ True
   - ☐ False

9. Patient or parental consent must be obtained before a patient's health information can be released to family members.
   - ☐ True
   - ☐ False

10. Protecting patient information includes all forms of communication – electronic, written and verbal.
    - ☐ True
    - ☐ False

Trainee - Signature X

*(Signature in **black** ink)*

Print Name (first-middle-last)

Date (month-date-year)

CHLA Div/Program

For CHLA Office Use ONLY:
Score: _____% By: JANE LEE Date: _____

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