MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS, INC.
NON-MCWAH HOUSESTAFF ASSIGNMENT FORM

Listed below is the form that is used to report assignments of Non-MCWAH housestaff to MCWAH institutions. The purpose of the form is to notify the administrator of the receiving hospital of the arrangements for professional liability coverage. This form is also used by the receiving hospital to claim Medicare reimbursement. A MCWAH housestaff time record must be completed and returned to the MCWAH Office at the conclusion of the rotation. The Confidentiality Agreement, Background Information Disclosure (BID) form and Consumer Authorization form must also be completed. Any changes to information provided on the Background Information Disclosure form must be reported to MCWAH or the MCWAH Program Director for your rotation within 24 hours. The resident must also attach a certificate of professional liability insurance, documentation of health requirements and proof of OSHA Bloodborne Pathogen Training compliance. This form should be signed by the resident's Program Director **and** the MCWAH Program Director. This form (and accompanying forms) should be sent to the MCWAH Office at least **3 months prior to the rotation**.

Non-MCWAH residents and fellows must have either a current Wisconsin Resident Educational License (REL) or a full and unrestricted current Wisconsin Medical License. A copy of the license must be provided to MCWAH as part of the rotation approval process. Information about each of these licenses can be obtained by the Wisconsin Department of Safety and Professional Services

MCWAH will assign a five-digit number to the resident and report that number back to the Program. The resident must use that number after his/her signature when making chart entries at CHW, FMLH or ZVAMC.

SECTION 1 To Be Completed by the Applicant.

Resident Name _____ Social Security # _____

Current Address _____

Phone Number _____ Email _____

Medical School _____ Graduation Date _____

If IMG, ECFMG # _____ Certificate Date _____ Date of Birth _____

Dates of MCWAH Rotation _____ to _____ MCWAH Program _____

NPI # _____ DEA #: _____

☐ WI REL # _____ ☐ WI License # (if applicable) _____

Please list all of your current and previous GME Training in the United States:

Name of Facility _____ Program _____ PG Level(s) _____

Dates of Training _____ to _____

Name of Facility _____ Program _____ PG Level(s) _____

Dates of Training _____ to _____

Additional Info/Training _____

Signature of Resident/Fellow **p < ÅSECTION pl ted by th^ Ap**

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SECTION 4 MCWAH Office Only. **Last Name** _____

1. Date Complete Documentation Received _____
2. Documentation of the Health Care Screening
   Documentation of health care screening is sent to MCW Occupational Health for review, approval and tracking.

Requirements	Received by MCWAH	Approved by Occupational Health	Complete
TB Testing			