UNIVERSITY OF KENTUCKY VOLUNTARY FACULTY APPLICATION/AGREEMENT

APPLICANT INFORMATION

Name _____ SS Number _____ Gender: ☐ M ☐ F

Date of Birth _____ Phone_____ Email _____

Race/Ethnicity (Check all that apply)

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American

☐ Hispanic/Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White

☐ Other_____

Birth Place _____ Citizenship _____

(City) (State) (Country)

Profession ☐ PT ☐ PA ☐ Nurse ☐ Dentist ☐ CLS ☐ Pharmacist ☐ Public Health

☐ Communications Disorders ☐ Physician ☐ Other_____

Specialty (Physicians)_____

ADDRESS

HOME

Street Address

City

State, County, Zip Code

Contact Phone Number

OFFICE

Employer's Name (if applicable)

Practice Name

Street Address

City

State, County, Zip Code

Office Phone/Office Fax

EDUCATION INFORMATION

Undergraduate Institution Attended _____ Degree _____ Year _____

Professional/Graduate Institution Attended _____ Degree _____ Year _____

Additional Post-Graduate Institution _____ Degree _____ Year _____

KENTUCKY LICENSE CERTIFICATION, REGISTRATION NUMBER

License Certification or Registration Number _____ Year _____

Specialty (if applicable) _____

License Certification or Registration Number _____ Year _____

Specialty (if applicable) _____

ALL GME TRAINING

Internship Institution _____ Residency Institution _____

Internship Specialty _____ Residency Specialty _____

Internship Year Completed _____ Residency Year Completed _____

Fellowship Institution _____

Fellowship Specialty _____

Fellowship Year Completed _____

BOARD CERTIFICATION DATES

Certification Types

☐ ABMS ☐ AOA ☐ ABMS Board Eligible ☐ Other Certification _____

Certification Status

☐ Time-Limited Currently Valid ☐ Time Unlimited ☐ Recertified

☐ MOCC/CC Requirements ☐ Osteopathic Continuous Certification ☐ Certification Lapsed

Original Certification Year _____

Year Re-Certified (if applicable) _____

RESIDENT & FELLOW SUPERVISION

Date you started supervising residents/fellows in graduate medical education programs? _____

Date you started supervising residents/fellows in a given specialty? _____

STUDENT SUPERVISION

If other providers in your practice will supervise trainees, they must have voluntary faculty appointments. Please list those providers: (Attach a separate sheet if necessary)

_____

_____

FOR CURRENT HOSPITAL OR CLINIC AFFILIATES

Will trainees accompany you or another supervisor to a hospital or clinic with which you are affiliated or have privileges? If yes, please list:

_____

_____

PLEASE BE SURE TO ATTACH THE FOLLOWING:

☐ Copy of your current vita or resume

If you answer YES to any of the following questions, please provide full details on a separate sheet.

A. Has your license, certification or registration to practice your current profession, or other professions, ever been limited, suspended or revoked in any jurisdiction? ☐ Yes ☐ No

B. Have your privileges at any hospital ever been suspended, diminished, removed or not renewed; or, has your employment ever been terminated? ☐ Yes ☐ No

C. Have you been denied membership or renewal thereof, or been subject to disciplinary action by any medical or professional organization or society? ☐ Yes ☐ No

D. Have you ever been named in any malpractice action? ☐ Yes ☐ No

E. Has your DEA registration been revoked, suspended or a complaint filed? ☐ Yes ☐ No

F. Do you have any physical or mental impairments that have restricted your work or would affect your ability to perform the duties of a preceptor? ☐ Yes ☐ No

G. Please indicate the amount of liability insurance you maintain. _____

Designation of College, Department/Division, Campus for which Voluntary Faculty status is requested:

College _____

Dept/Division _____

Campus _____

If you will precept students/residents from other disciplines and/or health professions, please list.

Discipline _____

Discipline _____

PLEASE READ AND SIGN THE FOLLOWING STATEMENTS

I have completed the entire Application/Agreement and have appended copies of requested material. I understand that holding voluntary faculty status is an important function in the University's education process. In making this Application/Agreement for appointment, I acknowledge my obligation to provide quality educational supervision, within the limits of my education and training, to students/residents that may be assigned to me and agree to provide such educational supervision under the following terms:

I hereby authorize the University and its representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated, licensure, registration or certification agencies, and with others who may have information bearing on my professional competence, health, character and ethical qualifications, and I hereby consent to the release of such information.

I hereby release from liability all representatives of the University for their acts performed in good faith and without malice in connection with evaluating my Application/Agreement and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to the University or its representatives, in good faith and without malice concerning my professional competence, ethics, character and other qualifications for appointment, including otherwise privileged information, and I hereby consent to the release of such information.

I hereby further authorize the University, in the event it is contacted, to communicate to other hospitals and to other persons or organizations with a legitimate interest therein, any information concerning my voluntary faculty status, professional competence, character and ethics that the University may have or acquire, and, where such communication is made in good faith and without malice, I consent thereto and agree to hold the University and its authorized representatives free of liability therefore.

I understand and agree that I, as an applicant for voluntary faculty status, have the burden of producing adequate information about my physical and emotional stability, as well as information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

I agree to inform UK HealthCare Risk Management (859) 257-6212 of any lawsuit which is threatened, or any patient care event which causes or contributes to injury or death and could result in a lawsuit if a University student/resident, employee or faculty member was involved with this event.

I agree to maintain medical liability insurance for myself, agents, officers, and employees in the amounts of not less than One Million ($1,000,000) Dollars per claim and Three Million ($3,000,000) Dollars aggregate per policy year, or such other minimum amounts as may be required from time to time by the University. The policy of insurance shall provide that such insurance shall not be canceled, modified or permitted to lapse without (30) days prior written notice to the University. I will promptly, following request by the University from time to time, provide evidence of such insurance acceptable to the University.

The University of Kentucky is an equal opportunity employer and I agree not to discriminate in regard to race, color, creed, age, sex, national origin or disability.

I affirm that I am not excluded from participation, and is not otherwise ineligible to participate in a “Federal health care program” as defined in 42 U.S.C. section 1320a-7b(f) or in any other state or federal government payment program. In the event that I am excluded from participation, or becomes otherwise ineligible to participate in any such program, during the term of any appointment resulting from this application, I will notify the Office of Corporate Compliance, University of Kentucky, 2333 Alumni Park Plaza, Suite 330, Lexington, Kentucky 40517 in writing, by certified mail within 48 hours after said event, and upon the occurrence of any such event, whether or not appropriate notice is given, the University of Kentucky, shall immediately terminate this Application/Agreement upon written notice.

Additionally, I affirm that I am aware that UKCMC operates in accordance with a corporate compliance program, employs a Corporate Compliance Officer and operates a 24 hour, seven day a week compliance Comply-line. I have been informed that a copy of the UKCMC compliance plan is on file in the purchasing office or can be viewed online at http://ukhealthcare.uky.edu/staff/corporate-compliance/policy-manual and I am encouraged to review the plan from time to time during the term of this agreement. It is understood that should I be found to have violated the UKCMC compliance plan, UKCMC can, at its sole discretion, terminate this Application/Agreement upon written notice. I recognize and confirm that I am under an affirmative obligation to immediately report to UKCMC's Corporate Compliance Officer through the comply-line (877) 898-6072, in writing, or directly (859) 323-8002 any actions by an agent or employee of UKCMC which I believe, in good faith, violates an ethical, professional or legal standard.

Nothing in this Application/Agreement contemplates or requires that any party act in violation of federal or state law.

Nonetheless, should any term or condition set forth in this Application/Agreement later be creditably alleged, suspected or determined to be illegal, the parties agree to immediately cease the questioned activity and negotiate modification to the effected portion of the Application/Agreement for a thirty (30) day period. If at the end of this period, no compromise can be reached, the Application/Agreement will terminate.

The University will direct students/residents to hold all individually identifiable patient health information ("Protected Health Information") that may be shared, transferred, transmitted, or otherwise obtained pursuant to the Application/Agreement strictly confidential, and to comply with your office's policies and procedures including those governing the use and disclosure of protected health information afforded by applicable federal, state, and local laws and/or regulations regarding the security and the confidentiality of patient health care information including, but not limited to, any regulations, standards, or rules promulgated pursuant to the authority of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Solely for the purpose of defining the students'/residents' role in relation to the use and disclosure of your office's protected health information, such students/ residents are defined as members of your office's "work force" as that term is defined by 45 CFR 160.103 when engaged in activities pursuant to the Application/ Agreement. However, such students/residents are not and shall not be considered to be employees of your office for other purposes. Furthermore, the University of Kentucky is not considered your business associate.

I agree to notify the University within fifteen (15) days in the event of an inquiry by the board into my practice or if my privileges are modified, suspended, or revoked at any facility where I am currently a member of the medical, dental, pharmacy, nursing or health sciences professions staff.

I agree to advise and obtain consent from those facilities for student/resident participation where students/residents will be with me during their clinical education rotation.

I fully understand that any falsification by commission or omission of this Application/Agreement constitutes cause for denial of appointment. All information submitted by me in this Application/Agreement is true to the best of my knowledge and behalf.

_____ _____

Signature of Applicant **Date**

_____

PLEASE PRINT NAME CLEARLY

FOR DEPARTMENT USE ONLY	
Nursing Only: ☐ Voluntary Faculty ☐ Preceptor Pharmacy Only: Field Professor:_____ Phone: ( )_____ AHEC Area: ☐NE ☐SE ☐SO ☐NC ☐WE ☐PU ☐NW ☐SC ☐ Not AHEC Date Received:___/___, 20__	Date Received by Department/Division:___/___/_____ Date Received by College: _____/_____/_____ Approved by Dean: _____(Initials) Date Approved: _____/_____/_____ Date Received by Provost: _____/_____/_____