

Office for Sponsored Staff
and
Volunteer Services

SPONSORED STAFF REGISTRATION FORM

PLEASE PRINT

Title _____ Last _____ First _____ MI _____

Current Address _____ Telephone _____
Street Area code number

City _____ State _____ Zip Code _____

E-mail Address _____

Date of Birth _____

If **Not** a US Citizen: I-94 Visa Type _____ Expiration Date: _____

In Emergency Notify _____ Relationship _____ Telephone _____
Area code number

BWH Department _____ Sponsor/Supervisor _____

Sponsor/Supervisor phone _____ Sponsor/Supervisor email _____

Are you being compensated? YES NO If yes, please provide the source _____

Will you be practicing medicine and/or assuming clinical duties at BWH? Yes No

If yes, you must contact your department administrator regarding the credentialing process prior to engaging in any clinical activities.

The following section should be completed at a Sponsored Staff Orientation session.

I understand BWH policies/procedures/practice standards.

Please initial each area: (Mark N/A where appropriate)

- _____ BWH Mission /Vision/Values;
- _____ Patient Rights;
- _____ HIPAA Regulations;
- _____ Confidentiality;
- _____ General Safety & Bodily Mechanics;
- _____ Emergency Procedures & Codes;
- _____ Infection Control training;
- _____ Accident & Incident Reporting;
- _____ ID Badge Policy;
- _____ Live Animal Training if appropriate;
- _____ Radiation, Nuclear, Hazmat Training if appropriate

I have completed the following: (Please check off)

Criminal Offender Record Information form -

Signed a commitment to confidentiality statement -

Safety Training Review Corrected by BWH staff - (*will be provided at Orientation*)

SUPERVISOR TO COMPLETE:

_____, will be in the Department of _____
Name of Sponsored Staff

_____, performing the following Duties:

**Please provide the start date _____ and exit date _____
for the Sponsored Staff in your department.**

Is this SS licensed as a physician in the state of Massachusetts? Yes No

Will s/he be practicing medicine and/or assuming clinical responsibilities at BWH? Yes No

If yes please contact BWH Provider Services to initiate the credentialing process. Credentialing must be completed before this person may engage in any clinical activities.

I understand that before I begin, I will participate in an on-site orientation. I understand I must complete immunization screening and obtain clearance. I certify that the information provided on this application is true and correct. I understand that any deliberate, incomplete, incorrect or false statements may result in dismissal. I understand that all offers to participate in a BWH Sponsored activity are conditional upon receipt of satisfactory CORI background check. I hereby release Brigham and Women’s Hospital and any persons or organizations that provide information from all legal responsibility or liability that may arise from conducting an investigation of my service.

Signatures:

Sponsored Staff _____ **Date:** _____

Department Supervisor _____ **Date:** _____

FOR PHYSICIANS, PHYSICIAN ASSISTANTS, AND ADVANCED PRACTICE REGISTERED NURSES ONLY:

I understand that I must be licensed and credentialed in the state of Massachusetts in order to provide any type of medical care or guidance at Brigham and Women’s Hospital (BWH). I understand that I must complete a formal BWH credentialing process and be approved for clinical privileges prior to engaging in any clinical activities.

Signature:

Sponsored Staff _____ **Date** _____