

UNIVERSITY OF KENTUCKY VOLUNTARY FACULTY APPLICATION/AGREEMENT

APPLICANT INFORMATION

Name: Click or tap here to enter text. Gender: M F Write-in: Click or tap here to enter text.
Date of Birth: Click or tap here to enter text. Phone: Click or tap here to enter text. Email: Click or tap here to enter text.
Race/Ethnicity: American Indian or Alaskan Native Asian Black or African American
(Check all that apply) Hispanic/Latino Native Hawaiian or Other Pacific Islander White
 Other
Birth Place: Click or tap here to enter text. Citizenship (if not US): Click or tap here to enter text.
(City) (State) (Country)

ADDRESS

Click or tap here to enter text.
Street Address
Click or tap here to enter text.
City
Click or tap here to enter text.
State, County, Zip Code
Click or tap here to enter text.
Contact Phone Number

HOME

PRACTICE SITE

Click or tap here to enter text.
Employer's Name (if applicable)
Click or tap here to enter text.
Practice Name
Click or tap here to enter text.
Street Address
Click or tap here to enter text.
City
Click or tap here to enter text.
State, County, Zip Code
Click or tap here to enter text.
Office Phone/Office Fax

EDUCATION INFORMATION

Click or tap here to enter text.
Undergraduate Institution Attended

Degree: Click or tap here to enter text.
Year: Click or tap here to enter text.

Click or tap here to enter text.
Professional/Graduate Institution Attended

Degree: Click or tap here to enter text.
Year: Click or tap here to enter text.

Click or tap here to enter text.
Professional/Graduate Institution Attended

Degree: Click or tap here to enter text.
Year: Click or tap here to enter text.

Click or tap here to enter text.
Additional Post-Graduate Institution Attended

Degree: Click or tap here to enter text.
Year: Click or tap here to enter text.

KENTUCKY LICENSE, CERTIFICATION, REGISTRATION NUMBER

License Certification or Registration Number: Click or tap here to enter text. Year: Click or tap here to enter text.

Specialty (if applicable): Click or tap here to enter text.

License Certification or Registration Number: Click or tap here to enter text. Year: Click or tap here to enter text.

Specialty (if applicable): Click or tap here to enter text.

PLEASE BE SURE TO ATTACH THE FOLLOWING:

- Copy of your current vita or resume Official Transcript: Undergraduate Degree Graduate Degree

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 ever 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. [Click or tap here to enter text.](#)

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