Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Include the following with Application for Research Hospital Appointment:

1. Letter of recommendation from the Department Head including a description of the activities to be undertaken by the applicant and a statement acknowledging that patients will be informed of the applicant's activities and will give permission for any research project with patient involvement.

2. Letter from the institution of primary affiliation, eg: college/university attesting as to the applicant's enrolment, if applicable.

3. Copy of Queen's HSREB approval letter (has to be dated within 1 year).

4. Brief curriculum vita

5. Confidentiality agreement from KHSC (included below) signed by the applicant.

6. Communicable Disease Health Clearance form (included below) is required for terms exceeding 90 days.

Applications will be processed by the Office of the Medical Director and brought to the Credentials Committee for recommendation to the Medical Advisory Committee.

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

APPLICATION FOR KINGSTON HEALTH SCIENCES CENTRE RESEARCH HOSPITAL APPOINTMENT

Please complete the following :

Title	
First Name	
Surname	
Date of Birth	
Home Address	
City/Prov/Postal Code	/ /
Home Telephone	
Cell Number	
Office Address	
Office Telephone	
Email Address	

Please check off which category/status applies to your position:

☐ **Principal Investigators (PI):** *is the lead clinical/basic/nursing scientist or engineer for a particular well-defined science research project, such as a laboratory study or clinical trial. These are individuals who are not a clinician (MD) or employees of the KHSC who work in research but instead have an affiliation with Queen's University, St. Lawrence College or any other applicable Academic Institution.*

- ☐ Queen's
- ☐ St. Lawrence College
- ☐ Other, please specify: _____

☐ **Research Support Staff:** *is an individual who provides research support services to the PI and overall research projects and initiatives. These individuals would likely be Queen's Employees or employees of KHSC or PC if their usual employment or appointment activities do not involve research.*

- ☐ Research Assistant
- ☐ Research Associate
- ☐ Research Coordinator
- ☐ Research Nurse/Allied Health Professionals (please specify:_____)
- ☐ Project Coordinator
- ☐ Project Leader
- ☐ Research Analyst
- ☐ Research Technician
- ☐ Research Administrative Assistant

☐ **Trainees:** *is an individual who is undergoing research training with a PI related to a scientific manner.*

- ☐ Post-doctoral Fellows
- ☐ Ph.D. students
- ☐ Masters students
- ☐ Medical students
- ☐ Undergraduate students
- ☐ Resident
- ☐ Visitor, please specify: _____

Hôpital Hotel Dieu Hospital
KGH Hôpital Général de Kingston General Hospital

1. Research Hospital Appointment required at: ☐ Hotel Dieu Hospital (HDH) Site ☐ Kingston General Hospital (KGH) Site

a) Please indicate % time at each site: _____% HDH _____% KGH

2. Are you currently employed by KHSC at this time? Yes ☐ No ☐

a) If so, what department do you work in? _____

3. Are you licensed: Yes ☐ No ☐

College of Physicians and Surgeons of Ontario:

Educational Register # _____ Date _____

Permanent Register # _____ Date _____

Registered Nurse:

Registration # _____ Date _____

Allied Professional, please specify: _____

Registration #_____ Date_____

4. Other qualifications, education, university degrees (including dates):

5. Please provide full description of your research duties:

6.

Start Date of Appointment	
End Date of Appointment or Renewable Term ** (Renewable yearly on July 1on approval by Department)	
If not the Principal Investigator, please provide the name of the PI or physician who will supervise your work	
Hospital Department/Research Unit/Research Centre	

**** If term of appointment is over 90 days or renewable, the Communicable Disease Health Clearance form is required. Form is at bottom of application**

7.

	Yes	No
Does this work directly involve the treatment of patients by the applicant? *(Please note that if the applicant is a physician, he/she must be licensed in Ontario and show evidence of membership in CMPA or equivalent to be permitted to be directly involved in the management of patients.)*		
Has HSREB approval been obtained? (**Attach copy of applicable REB**)		
Is the work affiliated with a Queen's teaching program?		
Are you presently enrolled in a Hospital/University teaching program?		
If so, please identify:		

I agree to abide by the by-laws, rules and regulations of KHSC, and other restrictions as defined on this application. *(Please find on KGH or HDH Internet and Intranet)* I will maintain the confidentiality of any information concerning patients that comes to my knowledge or possession with my Research Hospital Appointment.

Date_____**Signature**_____
APPLICANT

RECOMMENDATION OF PRINCIPAL INVESTIGATOR AND DEPARTMENT HEAD

The proposed research project as outlined above has received approval through the Queen's HSREB. As Principal Investigator (if applicable) and Department Head, I recommend the above named to hold a Research Hospital Appointment.

Comments or Restrictions: _____

_____

_____

Hospital Department_____

Signature_____ **Date:**_____
PRINCIPAL INVESTIGATOR (if applicable)

Signature_____ **Date:**_____
DEPARTMENT HEAD

Hôpital Hotel Dieu Hospital KGH Hôpital Général de Kingston General Hospital

Signature_____ Date: _____
KHSC VICE-PRESIDENT, HEALTH SCIENCES RESEARCH

Signature_____ Date: _____
HDH SITE DIRECTOR OF RESEARCH

RECOMMENDATION OF KHSC CREDENTIALS COMMITTEE

Comments or Restrictions: _____

_____

_____

Signature_____ Date:_____
CHAIR, KHSC CREDENTIALS COMMITTEE

HOSPITAL APPROVAL

Signature for KHSC_____ Date:_____
DIRECTOR, MEDICAL AFFAIRS

Kingston Health Sciences Centre
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STATEMENT OF CONFIDENTIALITY

It is Hospital Policy and law that all Hospital information is confidential. An employee, a member of the medical staff, volunteer, student or affiliate are agents of the Hospital and this statement applies to all agents. As an agent associated with the Hospital, you will have access to information and material relating to patients, employees, other individuals or the Hospital that is of a private and confidential nature.

1. The mission, principles and philosophy of the Hospital will be followed in accordance with the Hospital's rules and standards of conduct. At all times you will respect the privacy and dignity of patients and their families, employees and all associated individuals.

2. You will treat all Hospital administrative, financial, patient, employee and other records, whether written, verbal or electronically stored, as confidential material and you will protect it to ensure full confidentiality. You will not access records, discuss or use such information unless there is a legitimate purpose to do so in your normal Hospital duties and responsibilities. All hardware, software and other equipment are to be used for business purposes only. The Hospital may conduct periodic audits to ensure compliance and to ensure data integrity.

3. Any system User-ID(s) issued to you and/or any Password(s) created and personally entered by you into Hospital Information Systems are unique codes to identify you to the Hospital Information Systems. All access/entries made will be associated with your identity. You will protect the security of your signature code and you will not use the code of another person, or enable another person to know or use your code.

Confidentiality is the right of every patient and everyone affiliated with the Hospital. Each of us is expected to respect that right. A breach of any of these conditions will result in disciplinary action up to and including termination of employment, loss of privileges, sanctions specified in applicable law, or similar action appropriate to your position with the Hospital.

I have read and understand the conditions outlined in this statement. I have also been made aware of the Hospital's policies on security, privacy and confidentiality. I agree to abide by the Hospital Policy as a condition of my work with the Hospital.

Please indicate your Hospital agent type: Employee ☐ Medical Staff ☐ Volunteer ☐ Student ☐ Affiliate ☐

AGENT NAME (Please Print)	**WITNESS NAME** (Please Print)
SIGNATURE	**SIGNATURE**
DATE	**DATE**

(z:/privacy/forms/statement of confidentiality) revised 2017 June

Original Copy: Hospital File

Second Copy: Agent

Hôpital Hotel Dieu Hospital
KGH Hôpital Général de Kingston General Hospital

Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

KINGSTON HEALTH SCIENCES CENTRE
Communicable Disease Health Clearance Form

As a prerequisite for working at KHSC, individuals who carry on activities at either facility must meet the communicable disease surveillance requirements as stipulated in the Public Hospitals Act (Regulation 965). These requirements are outlined in the attached document entitled ***"Communicable Disease Health Clearance Requirements."*** Please do not include lab results.

In addition, Hepatitis B vaccination is recommended if you will be exposed to blood/body fluids as part of your appointment or placement. In cases where individuals interface with patients who are on airborne precautions (e.g. tuberculosis), they will be required to don an N95 respirator. To do so, the CSA standard requires the user to have been fit tested, trained, and medically cleared for respirator usage. The following N95 respirators are available for use at KHSC and HDH for those who have been fit tested & trained on their use: 3M 1860R, 3M 1860S, 3M 1870, 3M 8210, and 3M 8110S.

Should you have any questions specific to the requirements for applicants coming to KHSC, please contact KGH Occupational Health, Safety & Wellness Department at 613-549-6666 x 4389 or HDH Occupational Health & Safety Service at 613-544-3400 x 2264.

Your application will remain inactive and your privileges pending until required clearance by a physician/RN is provided to our office. Please have your physician/RN complete the following form and return to the KHSC Medical Administration office. If you do not have a local physician, Dr. Kozantitis at CDK Walk-In Clinic at 175 Princess Street (telephone 613-766-0318) has agreed to provide this service. The visit may be charged to OHIP (if you have OHIP coverage) however there will be a cost incurred for completion of the form and additional testing if required. CDK hours of operation are Monday-Friday 9am to 7pm; Saturday 10am to 2pm. The clinic only accepts cash and will provide a receipt as proof of payment.

Sincerely,

Gina Morey for

Christopher Gillies
Director, Medical Affairs

cc Department Head

Communicable Disease Health Clearance Requirements

as per Communicable Disease Surveillance Protocols (OHA/OMA)

Applicant's Name: Date:

Department of:

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FOR USE BY PHYSICIAN PROVIDING CLEARANCE TO APPLICANT

☐ Complete **TUBERCULOSIS SCREENING:**

a) Individuals whose tuberculin status is unknown, or those previously identified as tuberculin negative, require a baseline **two-step Mantoux skin test**, unless they have

- documentation of a prior two step Mantoux Skin Test, or
- documentation of a negative single step Mantoux Skin Test within the past 12 months, or
- two or more documented negative Mantoux Skin Tests at any time but the most recent was greater than 12 months ago,

in which case a single step Mantoux Skin test should be given and be current within 3 months of your start date.

b) For individuals who are known to be tuberculin positive, or for those who are tuberculin skin test positive when tested in (a) above, further assessment should be done which may include a chest radiograph (depending on when last done) and/or evaluation by the individual's health care provider to rule out active disease.

☐ **Complete MEASLES IMMUNITY:** only the following is accepted as proof of immunity:

- documentation of having received 2 doses of live measles virus vaccine on or after the first birthday, or
- serologic evidence (bloodwork) verifying immunity to measles

☐ **Complete MUMPS IMMUNITY:** only the following is accepted as proof of immunity:

- documentation of having received 2 doses of mumps vaccine (MMR) given at least 4 weeks apart on or after the first birthday, or
- serologic evidence (bloodwork) verifying immunity to mumps, or
- documentation of laboratory confirmed mumps

☐ **Complete RUBELLA IMMUNITY**: only the following is accepted as proof of immunity:

- serologic evidence (bloodwork) verifying immunity to rubella, or
- documented evidence of immunization with live rubella virus vaccine on or after the first birthday.

☐ **Complete <u>VARICELLA IMMUNITY</u>:** only the following is accepted as proof of immunity:

- a **definitive history** of having had chicken pox or herpes zoster
- in cases where the individual has not had chicken pox or is uncertain, they should be screened through bloodwork; if non-immune, they should be immunized with the varicella vaccine.

☐ **Complete <u>PERTUSSIS IMMUNITY</u>:** only the following is accepted as proof of immunity:

- immunization as an adult with one dose of T-dap (Tetanus-diphtheria acellular pertussis)

I _____, certify that _____
(PLEASE PRINT-Name of physician providing clearance) **(Name of applicant)**

has met the above communicable disease screening requirements for appointment to Kingston General Hospital and/or Hotel Dieu Hospital.

Health Care Professional's Last Name		First Name	
Full Address (No, Street)	City	Province	Postal Code
(Area Code) Telephone# _____		(Area Code) Fax #_____	
Signature		Date completed	

Please return completed form to:

KHSC Medical Administration
Kingston General Hospital, Watkins 4
76 Stuart St. Kingston, ON K7L 2V7
Fax 613-548-6082