Associated Health Trainee Application Package

The Medical and Associated Health Education office is available to assist health profession trainees Mondays through Fridays, 8:00 a.m. – 4:30 p.m. To coordinate a fingerprinting and photo appointment at the VA please call the Associated Health Program Manager at 504-412-3700 Ext: 8005

VA Office location:
1515 Poydras Street, 7th floor Room 736
New Orleans, LA
Office Number: 504-412-3700 ext. 8005 or ext. 8009
Fax number: 504-566-8415

New Student Application Checklist

Please only return the documents listed below:

- ☐ Signed Without Compensation Appointment Letter
- ☐ VA Application for Health Professions Trainee, VA form 10-2856d
- ☐ VA form 0711, Personal Identification Verification Card form
- ☐ Appointment Affidavit Standard Form 61, *can be signed by a notary or signed by a VA personnel official*
- ☐ Online TMS training certificate *see attached guide on how to create an account*
- ☐ Signature form of Numbered Memorandum 00-4, Protection of Patients From Abuse

DEPARTMENT OF VETERANS AFFAIRS
Southeast Louisiana Veterans Health Care System
P. O. Box 61011
New Orleans LA 70161-1011

In Reply Refer To: 629/002C

APPOINTMENT LETTER FOR TRAINEES PAID
THROUGH A DISBURSEMENT AGREEMENT

3/1/2016

Dear VA Health Professions Trainee:

Welcome to the Department of Veterans Affairs (VA) and the Southeast Louisiana Veterans Health Care System (SLVHCS). You will be given a ***without compensation appointment*** at our facility as a health profession trainee between June 1, 2016, through _____(***month/year of expected graduation date***), under the authority of Title 38 United States Code (U.S.C.) 7406. During your period of appointment to our facility, you will be paid by VA using a disbursement agreement with _____(***the name of affiliated school***) and will be authorized to perform services as directed by your SLVHCS Site Director.

Acceptance of this letter, as signified by your signature below, and completion of the Standard Form (SF) 61 prior to the start of your training, serves as your appointment authorization for this training period.

Sincerely yours,
/s/
Inger Alston
Chief, Human Resources Management Service

_____ _____
(Signature) (Date)

_____
(Print Name)

_____
(Home Address)

_____
(Name of School and Program)

OMB Number: 2900-0205
Estimated Burden: 30 minutes

Department of Veterans Affairs

APPLICATION FOR HEALTH PROFESSIONS TRAINEES

SEE LAST PAGE FOR PAPERWORK REDUCTION ACT, PRIVACY ACT AND INFORMATION ABOUT DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER

INSTRUCTIONS: Please submit this application furnishing all information in sufficient detail to enable the Department of Veterans Affairs (VA) to determine your eligibility for appointment. Type or print in ink. If additional space is needed, please attach a separate sheet and refer to items being answered by number. Applications for clinical training programs may require additional information. All information required by the training program to which you are applying, as well as information requested on all application forms, must be included.

VA must protect the safety of our patients. Therefore, at some point in the appointment process, you will be asked questions about your physical and mental health. This includes questions as to whether you have received tuberculin testing, hepatitis B vaccinations or any other vaccinations.

1A. NAME (Last, First, Middle)		1B. OTHER NAMES USED	
2. PRESENT ADDRESS (Include ZIP Code)		3A - PRIMARY PHONE (Include area code) 3B - ALTERNATE PHONE (Include area code)	
4. SOCIAL SECURITY NUMBER	5A. PRIMARY EMAIL ADDRESS	5B. ALTERNATE EMAIL ADDRESS	6. DATE OF BIRTH (mm/dd/yyyy)
7A. VA TRAINING FACILITY (City, State)	7B. VA TRAINING START DATE (mm/yyyy) ☐ UNKNOWN	7C. VA TRAINING END DATE (mm/yyyy) ☐ UNKNOWN	

II - U.S. MILITARY DUTY STATUS

8A. ARE YOU NOW IN U.S. MILITARY?	8B. ARE YOU IN THE RESERVES OR NATIONAL GUARD?	8C. BRANCH OF SERVICE
☐ YES *(If YES, complete 8c)* ☐ NO	☐ YES *(If YES, complete 8c)* ☐ NO	

III - CITIZENSHIP

9A. CITIZENSHIP	9B. COUNTRY OF CITIZENSHIP
☐ U.S. CITIZEN BY BIRTH ☐ NATURALIZED U.S. CITIZEN ☐ NOT A U.S. CITIZEN (Complete item 9B)	

NOTE: Complete items 10A, 10B, 10C, or 10D ONLY if you are NOT a U.S. citizen.

10A. IMMIGRANT	10B. EXCHANGE VISITOR		10C. OTHER NON-IMMIGRANT		10D. FORM DS2019
"A" NUMBER	VISA TYPE	VISA NUMBER	VISA TYPE	VISA NUMBER	DO YOU HAVE A VALID DS2019? ☐ YES ☐ NO
DATE	ISSUE DATE	EXPIRATION DATE	ISSUE DATE	EXPIRATION DATE	DATE OF LAST VALIDATION (MM/DD/YYYY)

IV- THIS SECTION TO BE COMPLETED BY DESIGNATED EDUCATION OFFICER (DEO) OR DESIGNEE

11A. The trainee has met all of the criteria of the Trainee Qualifications & Credentials Verification Letter (TQCVL)	☐ YES ☐ NO
11B. Incomplete items on the TQCVL have been addressed and resolved	☐ YES ☐ NO
11C. Special attention has been given to the following items from the application forms	
11D. Comments	
11E. This applicant has been approved for appointment.	☐ YES ☐ NO
11F. Comments	

12A. SIGNATURE OF FACILITY DESIGNATED EDUCATION OFFICER OR DESIGNEE	12B. TITLE	12C. DATE

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

V- LICENSE, CERTIFICATION, OR REGISTRATION IN CURRENT CLINICAL PROFESSION

13A LIST ALL LICENSES, CERTIFICATIONS AND REGISTRATIONS, INCLUDING THE DRUG ENFORCEMENT AGENCY (DEA), THAT YOU HAVE NOW OR HAVE HAD AS A HEALTH PROFESSIONAL (I.E. MEDICAL, NURSING, PHARMACY, ETC)	13B STATE ISSUING LICENSE	13C LICENSE, CERTIFICATION OR REGISTRATION NUMBER	13D EXPIRATION DATE (MM/DD/YYYY)

VI- LICENSE, CERTIFICATION, OR REGISTRATION IN OTHER/PREVIOUS CLINICAL PROFESSION(S)

14A LIST ALL LICENSES, CERTIFICATIONS, AND REGISTRATIONS, INCLUDING DEA, THAT YOU HAVE EVER HAD AS A HEALTH PROFESSIONAL, I.E. MEDICAL, NURSING, PHARMACY, ETC	14B STATE ISSUING LICENSE	14C LICENSE, CERTIFICATION OR REGISTRATION NUMBER	14D EXPIRATION DATE (MM/DD/YYYY)

15. ENTER YOUR NATIONAL PROVIDER IDENTIFIER (NPI)

The following two questions apply to both your current health profession and any prior health profession.

16. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD ANY LICENSE, CERTIFICATION, OR REGISTRATION TO PRACTICE (INCLUDING DEA CERTIFICATE) REVOKED, SUSPENDED, DENIED, RESTRICTED, OR PLACED ON A PROBATIONARY STATUS OR HAVE YOU EVER VOLUNTARILY RELINQUISHED A LICENSE, CERTIFICATION, OR REGISTRATION IN LIEU OF FORMAL ACTION? ☐ YES - EXPLAIN IN PART XI ☐ NO

17. DO YOU HAVE PENDING, OR HAVE YOU EVER HAD CLINICAL PRIVILEGES AT ANY HEALTH CARE INSTITUTION OR AGENCY REVOKED, SUSPENDED, DENIED, RESTRICTED, LIMITED, OR PLACED ON A PROBATIONARY STATUS OR HAVE YOU EVER VOLUNTARILY RELINQUISHED CLINICAL PRIVILEGES IN LIEU OF FORMAL ACTION? ☐ YES - EXPLAIN IN PART XI ☐ NO

VII - EDUCATION AND TRAINING AFTER HIGH SCHOOL THROUGH GRADUATE / PROFESSIONAL SCHOOL (Continue in Part XI if necessary)

18A NAME OF SCHOOL	18B ADDRESS (City, State, and Zip Code)	18C START DATE (MM/YY)	18D (EXPECTED) COMPLETION DATE (MM/YY)	18E DIPLOMA, DEGREE OR CERTIFICATE AWARDED OR IN PROGRESS	18F MAJOR FIELD OF STUDY

VIII - GRADUATES OF AN INTERNATIONAL MEDICAL SCHOOL

19A ARE YOU A GRADUATE OF AN INTERNATIONAL MEDICAL SCHOOL? ☐ YES ☐ NO	19B EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES (ECFMG) CERTIFICATE NUMBER	19C ECFMG CERTIFICATE DATE

IX- INTERNSHIP, RESIDENCY AND FELLOWSHIP TRAINING

20A NAME OF HOSPITAL OR INSTITUTION	20B ADDRESS (City, State and ZIP Code)	20C SPECIALTY	20D START DATE (MM/YY)	20E (EXPECTED) COMPLETION DATE (MM/YY)	20F NUMBER OF MONTHS COMPLETED

LAST NAME, FIRST NAME, MIDDLE NAME	SOCIAL SECURITY NUMBER

AUTHORIZATION FOR RELEASE OF INFORMATION

In order for the Department of Veterans Affairs (VA) to assess and verify my educational background, professional qualifications and suitability for employment, I:

- ☐ Authorize VA to make inquiries about me to current and previous employers, educational institutions, state licensing boards, professional liability insurance carriers, other professional organizations or persons, agencies, organizations, or institutions listed by me as references, and to any other sources which VA may deem appropriate or be referred by those contacted;
- ☐ Authorize release of such information and copies of related records and documents to VA officials;
- ☐ Release from liability all those who provide information to VA in good faith and without malice in response to such inquiries;
- ☐ Authorize VA to disclose to such persons, employers, institutions, boards, or agencies identifying and other information about me to enable VA to make such inquiries; and
- ☐ Authorize VA to share any information about me with the affiliated institution or training program official.

SIGNATURE OF APPLICANT	DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

Public reporting burden for this collection of information is estimated to average 30 minutes, including the time for reviewing instructions, searching existing data sources, gathering data, completing, and reviewing the information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to VA Clearance Officer (005R1B), 810 Vermont Avenue NW, Washington, DC 20420. Do not send applications to this address.

AUTHORITY: The information requested on this form and Authorization for Release of Information is solicited under Title 38, United States Code, Chapters 73 and 74.

PURPOSES AND USES: The information requested on the application is collected to determine your qualifications and suitability for appointment to a VA clinical training program. If you are appointed by VA, the information will be used to make pay and benefit determinations and in personnel administration processes carried out in accordance with established regulations and systems of records.

ROUTINE USES: Information on the form may be released without your prior consent outside the VA to another federal, state or local agency. It may be used to check the National Practitioner Health Integrity and Protection Data Bank (HIPDB) or the List of Excluded Individuals and Entities (LEIE) maintained by Health and Human Services (HHS), Office of Inspector General (OIG), or to verify information with state licensing boards and other professional organizations or agencies to assist VA in determining your suitability for a clinical training appointment. This information may also be used periodically to verify, evaluate, and update your clinical privileges, credentials, and licensure status, to report apparent violations of law, to provide statistical data, or to provide information to a Congressional office in response to an inquiry made at your request. Such information may be released without your prior consent to federal agencies, state licensing boards, or similar boards or entities, in connection with the VA's reporting of information concerning your separation or resignation as a professional staff member under circumstances which raise serious concerns about your professional competence. Information concerning payments related to malpractice claims and adverse actions which affect clinical privileges also may be released to state licensing boards and the National Practitioner Data Bank. Information will be stored in a confidential and secure VA database for purposes of processing your application and may be verified through a computer matching program. Information from this form may also be used to survey you regarding employment opportunities in VA and to solicit you perceptions about your clinical training experiences at VA and non-VA facilities.

EFFECTS OF NON-DISCLOSURE: See statement below concerning disclosure of your social security number. Completion of this form is mandatory for consideration of your application for a clinical training position in VA; failure to provide this information may make impossible the proper application of Civil Service rules and regulations and VA personnel policies and may prevent you from obtaining employment, employee benefits, or other entitlements.

INFORMATION REGARDING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER UNDER PUBLIC LAW 93-579 SECTION 7(b)

Disclosure of your Social Security Number (SSN) is mandatory to obtain the employment and benefits that you are seeking. Solicitation of the SSN is authorized under provisions of Executive Order 9397 dated November 22, 1943. The SSN is used as an identifier throughout your Federal career. It will be used primarily to identify your records. The SSN also will be used by Federal agencies in connection with lawful requests for information about you from former employers, educational institutions, and financial or other organizations. The information gathered through the use of the number will be used only as necessary in personnel administration processes carried out in accordance with established regulations and published notices of systems of records, 'Applicants for Employment' under Title 38, U.S.C.-VA (02VA135), in the 2003 Compilation of Privacy Act Issuances. The SSN will also be used for the selection of persons to be included in statistical studies of personnel management matters. The use of the SSN is necessary because of the large number of Federal employees and applicants with identical names and birth dates whose identities can only be distinguished by the SSN.

Please fill out the necessary information which is required from the
"VA FORM 0711 REQUEST FOR PERSONAL IDENTITY VERIFICATION"

PRINT CLEARLY

Name: (Last, First, MI): _____

Date of Birth (XX/XX/XXXX): _____

Social Security Number (XXX-XX-XXXX): _____

Mobile phone (XXX-XXX-XXXX): _____

Email:_____

Name of VA Supervisor (*If assigned*):_____

Gender: ☐ Male ☐ Female

Race: (*choose one only*) ☐ American Indian ☐ Caucasian ☐ Hispanic
☐ Black-Non-Hispanic ☐ Asian/Pacific Islander

Height (X'X"): _____

Weight (pounds): _____

Eye color: (*choose one only*) ☐ black ☐ blue ☐ brown ☐ multicolored
☐ green ☐ hazel ☐ gray

Hair color: (*choose one only*) ☐ black ☐ blonde ☐ brown ☐ gray ☐ red
☐ white ☐ none

Place of Birth (*CITY and STATE*): _____

Place of Birth (*CITY and STATE*): _____

APPOINTMENT AFFIDAVITS

_____ _____
(Position to which Appointed) (Date Appointed)

Southeast Louisiana VA HCS | 629 | New Orleans, LA
(Department or Agency) (Bureau or Division) (Place of Employment)

I, _____, do solemnly swear (or affirm) that--

A. OATH OF OFFICE

I will support and defend the Constitution of the United States against all enemies, foreign and domestic; that I will bear true faith and allegiance to the same; that I take this obligation freely, without any mental reservation or purpose of evasion; and that I will well and faithfully discharge the duties of the office on which I am about to enter. So help me God.

B. AFFIDAVIT AS TO STRIKING AGAINST THE FEDERAL GOVERNMENT

I am not participating in any strike against the Government of the United States or any agency thereof, and I will not so participate while an employee of the Government of the United States or any agency thereof.

C. AFFIDAVIT AS TO THE PURCHASE AND SALE OF OFFICE

I have not, nor has anyone acting in my behalf, given, transferred, promised or paid any consideration for or in expectation or hope of receiving assistance in securing this appointment.

_____
(Signature of Appointee)

Subscribed and sworn (or affirmed) before me this____ day of _____ , 2_____

at _____ _____
(City) (State)

_____
(Signature of Officer)

(SEAL)

Commission expires_____ _____
(If by a Notary Public, the date of his/her Commission should be shown) (Title)

Note - If the appointee objects to the form of the oath on religious grounds, certain modifications may be permitted pursuant to the Religious Freedom Restoration Act. Please contact your agency's legal counsel for advice.

Mandatory Training for Trainees

Prior to coming to VA to begin your clinical training, you are required to complete a mandatory self-enrolled training program titled ***VHA Mandatory Training for Trainees***. This training is available through the VA Talent Management System (TMS). Follow the steps listed below to create your profile.

Each health professions trainee will need the following information in order to complete the self-enrollment process in the TMS:

- VA Location Code: NOL
- VA Point of Contact First Name: Philippe
- VA Point of Contact Last Name: Debyser
- VA Point of Contact Email address: Philippe.Debyser@va.gov

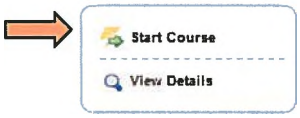
1.1 Step-by-Step Instructions

1. From a computer, launch a web browser and navigate to http://www.tms.va.gov
2. Click the [**Create New User**] link located below the **[SIGN IN]** button.
3. Select the radio button for ◉ **Health Professions Trainee**
4. Click the [**Next**] button
5. Complete all required fields and any non-required fields if possible.
    a. My Account Information:
        i. Create Password
        ii. Re-enter Password
        iii. Security Question
        iv. Security Answer
        v. Social Security Number* (*If you do not have a Social Security Number, follow the on-screen instructions when registering).*
        vi. Re-enter Social Security Number
        vii. Date of Birth
        viii. Legal First Name
        ix. Legal Last Name
        x. E-mail Address *(Enter your personal email address. The e-mail address will be used as your User ID when you login)*
        xi. Re-enter your e-mail address
        xii. Phone Number *(Enter a number where you can be reached by VA staff if issues arise with this self-enrollment process or in other circumstances)*
    b. My Job Information:
        i. VA City – *(**New Orleans**)*
        ii. VA State – *(**LA**)*
        iii. VA Location Code – *(**NOL**)*
        iv. Trainee Type
        v. Specialty/Discipline
        vi. VA Point of Contact First Name: ***Philippe***
        vii. VA Point of Contact Last Name: ***Debyser***
        viii. VA Point of Contact Email: ***Philippe.Debyser@va.gov***

Once you have entered all of the required data, click the "**Submit**" button. Your profile will be immediately created. Copy and save the **User ID** displayed to you on the confirmation page, as you will need this for future logons to the VA TMS. Once done, click on the "**Continue**" button and wait until your "**To-Do**" list is displayed with the title of the mandatory training course.

1.2 Launching and Completing the Content

1. Mouse over the title of the *VHA Mandatory Training for Trainees* training course.
2. Click the [**Start Course**] button



3. Complete the course content following the on-screen instructions.
4. Exit the course and a completion of the course will be recorded for your effort.

5. Click on the "**Completed Work**" link on the lower right hand side of your internet browser window.
6. Move your mouse over the title of the course you just completed and select "**Print Certificate**".

7. Print your completion certificate and save it in a pdf file for your records.
8. When you report to VA, bring the **Certificate of Completion** for your mandatory training for verification by VA personnel.

1.3 Trouble-shooting and Assistance

The **Check System** link on the VA TMS is an automated tool that confirms the existence of basic, required software on the computer you are using to complete this training.
If one of the components on your computer is not in compliance with the requirements, a red "x" will appear next to the **Check System** link. If the System Check shows red x's, please follow the instructions to bring your computer up to the standards that will work with the VA TMS.

If you do not have a Social Security Number, or if you experience any difficulty creating a profile or completing the mandatory content, contact the VA MSE Help Desk at 1.866.496.0463 or via email at vatmshelp@va.gov. If you have worked at a VA facility before, please let us know so that you may be moved to the New Orleans domain in TMS. You will not need to create a new MSE-TMS account.

** Your SSN is used only as a unique identifier in the system to ensure users do not create multiple profiles. The SSN is stored in a Private Data Table that cannot be accessed anywhere via the VA TMS interface. It is securely transferred to a VA database table inside the VA firewall where it can be confirmed, if necessary, by appropriately vested system administrators and/or Help Desk staff.*

Southeast Louisiana Veterans Health Care System
New Orleans, LA 70112

Department of Veterans Affairs

Numbered Memorandum

00-4
October 17, 2012

PROTECTION OF PATIENTS FROM ABUSE

1. **PURPOSE**: The purpose of this Numbered Memorandum (NM) is to describe policy and procedures for the protection of patients from real or perceived abuse, neglect, or exploitation by employees, students, volunteers, other patients, visitors or family members. The policy contained in this Numbered Memorandum applies to any patient in any capacity of Southeast Louisiana Veterans Health Care System (SLVHCS).

2. **POLICY**:

a. Patient abuse, whether physical, verbal, or psychological, is unacceptable. Employees will treat all patients with kindness and respect.

b. Penalty: If patient abuse is proven, the administrative action is usually removal; however, progressive disciplinary action will be considered based on the circumstances of the incident, severity of the incident, and the employee's record.

c. Disciplinary Action: Disciplinary action will also be taken in accordance with appropriate regulations if:

(1) an employee fails to report patient abuse to the proper authorities;

(2) a management official fails to immediately conduct a thorough investigation into any reported patient abuse; or

(3) an employee intentionally makes false or unfounded charges of patient abuse against another employee.

d. Definitions: Patient abuse, whether or not provoked, is defined as acts against patients which involve:

(1) Physical/Sexual Abuse (some examples include, but are not limited to): Striking/attacking; sexual assault/harassment/coercion; unreasonable physical constraint; deprivation of food, medication, or water; inappropriate use of physical or chemical restraint; neglect; failure to assist with personal hygiene; failure to protect from health and safety hazards; and intentional omission of care.

(2) Psychological/Mental Abuse (some examples include, but are not limited to): Subjecting a person to fear, isolation or emotional distress; withholding emotional support; willful violation of a patient's privacy, harassment, ridicule and intimidation (such as following an individual or getting too close to their physical being – violating an acceptable space zone) to bring about a certain effect.

(3) Verbal Abuse is cursing; yelling; expressing indifference; ridiculing; or threatening a patient. Some examples include but are not limited to:

EXAMPLES OF PATIENT ABUSE	EXAMPLES OF INAPPROPRIATE CONDUCT
Profanity directed at the patient.	Profanity not directed at the patient.
Yelling—Hostile with emotional component; e.g., "Shut up and Sit Down!"	Loud interaction—but with instructional intent (lacks emotional component).
Indifference-Overt statement; e.g., "I don't care what happens to you."	Apathetic (flat, uncaring) affect.
Ridicule-Words or actions that make fun of a patient.	Inappropriate joking, which offends a patient, but, is not focused at a patient.
Implied or Overt threat to a patient.	Failure to attempt to defuse or de-escalate a patient's aggressive behavior toward staff.

Inappropriate employee conduct will be referred to the appropriate supervisor for administrative action.

(4) Exploitation: Taking unjust advantage of another for one's own advantage or benefit. Examples may include but are not limited to:

EXAMPLES OF EXPLOITATION
Direct or indirect request for money for performing basic services (i.e., "The patient across the hall gave me $10 when I bathed him.").
Using patient's credit card for personal use(i.e., telling patient child needs clothes, school books, etc. that you can't afford)
Borrowing money
Photographing patient without his/her consent, then using photographs for reasons not related to his/her VA medical care.

3. **RESPONSIBILITIES**:

a. Assistant Director:

(1) During New Employee Orientation, Workforce Development Services will:

(a) provide every new employee with a copy of this Numbered Memorandum;

(b) discuss "Protection of Patients From Abuse";

(c) obtain the employee's signature on Attachment A to this Numbered Memorandum certifying his/her receipt, understanding, and agreement to comply with this policy; and

(d) forward signed receipts to the employee's immediate supervisor for filing in the employee's Official Personnel Folder.

(2) The Chief of Workforce Development Services or designee will provide annual mandatory training for all employees regarding the content of this policy via the Talent Management System (TMS).

b. Service Chiefs will notify the Director within 24 hours of an alleged report of patient abuse. As appropriate, the Associate Director, Chief of Staff, Associate Director, Patient/Nursing Services, and/or Assistant Director will also be contacted.

c. Mid-level Managers/Supervisors will assure the timely examination of any potential physical injury to the patient and the submission of VA Form 10-2633 found at http://www4.va.gov/vaforms/medical.pdf/vha-10-2633-fill.pdf in compliance with Numbered Memorandum, Patient Safety Improvement Program.

d. Employees will:

(1) complete Part 1 of VA Form 10-2633, Report of Special Incident Involving a Beneficiary, when they are advised of, perceive, or witness any abuse of a patient within 24 hours; and

(2) Immediately give VA Form 10-2633 to their immediate supervisor who will report to the appropriate Service Chief and the Patient Safety Manager.

4. **PROCEDURES**: The Director/designee will determine if an incident meets the definition of patient abuse.

a. When allegations of patient abuse are raised, the Director/designee may order a preliminary investigation (Fact Finding Investigation) to determine if an Administrative Investigation Board (AIB) is necessary.

b.

c. If definition of patient abuse is met, the AIB will recommend that "appropriate administrative action" be taken against the employee(s). The Director will be the final approving official of all recommendations.

d. If the definition of patient abuse is not met, the matter will be closed or referred to the appropriate Service Chief for appropriate action, if there has been a finding of inappropriate employee conduct.

e. Occasionally, a patient may use allegations of patient abuse or threaten such allegations to manipulate staff. In some instances, a patient may not be oriented to reality. These situations require a VA Form 10-2633 and an initial review, but are exceptions to the requirement for an AIB. The reasons for not initiating an AIB must be clearly documented and approved by the Director. This information will be maintained by the Risk Manager.

5. **RESCISSION**: Numbered Memorandum, Protection of Patients From Abuse, dated December 29, 2009.

6. **REFERENCES**: VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4, 2011; VA Handbook 5021, Part 1, Appendix A, "for Title 5 & hybrid - Table of Examples of Offenses and Penalties"; The Joint Commission Comprehensive Accreditation Manual for Ambulatory Service, Comprehensive Accreditation Manual for Home Care, and Comprehensive Accreditation Manual for Behavioral Health Care, current edition, located on the Intranet; and Numbered Memorandum, Patient Safety Improvement Program, dated July 6, 2012, located on the intranet-; Numbered Memorandum, Code of Conduct dated September 21, 2009.

7. **FOLLOW-UP RESPONSIBILITY**: Patient Care Coordinator (00E2).

8. **EXPIRATION DATE**: October 31, 2015.

(signed)
Jimmy A. Murphy
Director

See Attachment:

SUMMATION OF POLICY & PROCEDURE CHANGES:

This policy has been updated to reflect ((1) a change in responsibilities, to the Assistant Director and Workforce Development Services in lieu of the Associate Director, Patient/Nursing Services specific to Section 3.a, 3.a.1, and 3.a.(2); (2) a change in responsibility to forward the employee's signed receipt to the employee's immediate supervisor in lieu of Human Resources Management, Section 3.a.(1).(d); (3) replacing My Peak with Talent Management System (TMS) as the current learning management system, Section 3.a.(2); (4) adding the Assistant Director to Section 3.b.; (5) the current VHA Handbook dated March 4, 2011, the Joint Commission Comprehensive Accreditation Manual for Home Care and Behavioral Health Care, and current NM, Patient Safety Improvement Program dated July 6, 2012; and (6) the addition of Numbered Memorandum, Code of Conduct dated September 21, 2009.

Attachment A
Numbered Memorandum 00-4

From: Assigned SLVHCS Health Professions Trainee

To: Southeast Louisiana Veterans Health Care System Director (00)

Subj: Patient Abuse or Mistreatment

1. I have received, understand, and will abide by the provisions of Numbered Memorandum 00-4, "Protection of Patients from Abuse". I will not abuse any patient and will not tolerate it happening in my presence.

2. If patient abuse is witnessed, perceived, or suspected, I will immediately report it to my supervisor and/or appropriate management official (i.e. Charge Nurse, Clinic Managers, Service Chiefs, etc.).

3. I will immediately complete Part I of VA Form 10-2633, Report of Special Incident Involving a Beneficiary, giving a detailed account of the circumstances.

4. I will cooperate fully with any investigation into patient abuse.

_____	_____	_____
Print Name	Signature	Date