BWH BRIGHAM AND WOMEN'S HOSPITAL

POI FORM

To be completed by Manager or Department Administrator

Forms Checklist:
- CORI Request Form ☐
- CORI Request (Child contact) ☐
- Confidentiality Agreement ☐
- Research Trainee Letter ☐
- Pre-placement Health Screens ☐
- Minor Consent OHS) ☐
- Lab Minor Consent Form ☐

Start Date ______________

Biographical Information -PeopleSoft Required Fields

First Name ______________ ______________ Last Name ______________

Date of Birth (mm/dd/yyyy) ______ Gender ______ Social Security Number ______________ Ethnicity ______________

Address ______________________________ City ______________

State/ Country ______ Zip ______ Phone ______________ Email ______________ End Date(approximate) ______________

License Information (*skip this section if it does not apply to you*) Does the POI hold a work related license? ______

License Type ______ License Number ______ Expiration Date ______ Issuing Agency ______ Issuing State ______

US Citizen? ______ If no, authorized to work in U.S? ______ Work Visa/Authorization Type (*include permanent resident*) ______

Work Authorizing Document # ______________________________ Expiration Date ______________

Emergency Contact(optional) ______________________________ Phone ______________

FOR ALL POI's:
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.

Signature/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/Date ______________

To be Completed by Manager or Department Administrator

HR department (BR# or BD#) ______ Department name ______________

Is the POI being Compensated? Pay Source ______________

Will the person be practicing medicine &/or assuming clinical duties? ______ Will the person have contact with children? ______

What is the POI's Role? ______________________________

Work Schedule (*hours per day & day of the week*) ______________________________

Please describe duties/responsibilities:

Access to Partners Network needed? Yes Email account needed? Yes Is the POI Working Remotely? ______

Primary Work Location (*address, building name & floor*) ______________________________

Requesting Manager/Dept Administrator ______________ Signature ______________ Form completed by ______________

OSSVS/ HR Section

POI Type: ______________ CORI- Date Submitted ______________ CORI- Date Received ______________

OHS Clearance Date ______________ Orientation Date ______________ PeopleSoft ID# ______________

Confidentiality Agreement ☐ Type of Volunteer ______________