



## Compliance Training Enrollment Request Form

Form completed by:

\*Date of  
Orientation:

Authorized supervisor/Department Admin.

New Employee Orientation Attendee\*

### Compliance Training Enrollment Information

First Name (Please PRINT)

Last Name

Department

2 Digit

2 Digit

Month of Birth

Day of Birth

Division (if applicable)

Dept. Administrator Name

Job Title / Role

Supervisor

Job Type (if applicable)

NPI Number (if  
applicable)

License /  
Credential

Resident

Faculty

Volunteer

Staff

Vendor - Name:

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### Role Related Information

Employer

Location

State

UHB

UPB

BSB

RF

HSEB

Off-site /Other

Please turn over to complete

**Access** (Please select all that apply)

Individual has access to patient information

Individual documents / reviews medical records

Comments:

Individual performs registration/  
billing functions for:

Hospital (UHB)

Physician Practice Plan (UPB)

None of the above

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**Signature of Department Administrator**

I attest that the above listed individual has undergone proper 'on-boarding' including background check / exclusion screening / employee health screening (etc.) as applicable. I attest that the information above is accurate and can be relied upon to determine the appropriate training curriculum.

I understand that it will be the Department's responsibility to ensure that any training required is completed in a timely manner.

Signature / Name

Date

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**Signature of New Employee Orientation Attendee**

By signing below I attest to receipt of the following materials:  
Compliance Web-based Training Instructions, HIPAA Pocket Guide, Internal Control, Compliance Line, DRA and Code of Conduct Brochures.

Signature