

**NEW YORK CITY HEALTH AND HOSPITALS CORPORATION  
INDIVIDUAL HOUSE STAFF CONTRACT**

|                    |                                               |
|--------------------|-----------------------------------------------|
| <b>INSTITUTION</b> | LINCOLN MEDICAL & MENTAL HEALTH CENTER        |
| <b>ADDRESS</b>     | 234 East 149th Street, Bronx, New York, 10451 |

**BIOGRAPHICAL INFORMATION**

|                                                                                                                                 |                    |                     |                  |                        |                     |
|---------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------|------------------|------------------------|---------------------|
| <b>NAME</b>                                                                                                                     |                    |                     |                  |                        |                     |
| <b>HOME ADDRESS</b>                                                                                                             |                    |                     |                  |                        |                     |
| <b>MAILING ADDRESS</b>                                                                                                          |                    |                     |                  |                        |                     |
| <b>GRADUATE IN:</b><br><input type="checkbox"/> DENTISTRY <input type="checkbox"/> MEDICINE <input type="checkbox"/> OSTEOPATHY |                    |                     |                  | <b>GRADUATION DATE</b> |                     |
| <b>NAME &amp; ADDRESS OF DENTAL, MEDICAL OR OSTEOPATHIC SCHOOL</b>                                                              |                    |                     |                  |                        |                     |
| <b>ECFMG NO.</b>                                                                                                                | <b>DATE ISSUED</b> | <b>DATE EXPIRES</b> | <b>FMGEM NO.</b> | <b>DATE ISSUED</b>     | <b>DATE EXPIRES</b> |

**PREVIOUS HOUSE STAFF TRAINING\***

|                                    |              |                                          |                                                                                                            |
|------------------------------------|--------------|------------------------------------------|------------------------------------------------------------------------------------------------------------|
| <b>DATES</b>                       | <b>FROM:</b> | <b>TO:</b>                               | <b>ACGME, ADA, APA, RSPSC or AOA APPROVED?</b><br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <b>HOSPITAL NAME &amp; ADDRESS</b> |              |                                          |                                                                                                            |
| <b>RESIDENCY PROGRAM</b>           |              | <b>PERIOD OF RESIDENCY PROGRAM YEAR-</b> |                                                                                                            |

**LICENSE/PERMIT INFORMATION**

|                                                                                                        |                      |                    |                     |
|--------------------------------------------------------------------------------------------------------|----------------------|--------------------|---------------------|
| <b>N.Y. STATE LIMITED PERMIT NO.</b>                                                                   | <b>DATE ELIGIBLE</b> | <b>DATE ISSUED</b> | <b>DATE EXPIRES</b> |
| <b>N.Y. STATE LICENSE NO.</b>                                                                          | <b>DATE ELIGIBLE</b> | <b>DATE ISSUED</b> | <b>DATE EXPIRES</b> |
| IF NOT LICENSED, INDICATE DATE YOU BECAME OR WILL BECOME ELIGIBLE TO TAKE NEW YORK STATE LICENSE EXAM. |                      |                    |                     |

**APPOINTMENT INFORMATION**

|                                                                                                                                                                                        |                                                                                                                                             |                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| <b>SERVE AS:</b><br><input type="checkbox"/> Dental Resident <input type="checkbox"/> Junior Psychiatrist<br><input type="checkbox"/> Chief Resident <input type="checkbox"/> Resident | <b>PGY LEVEL</b><br><b>PL LEVEL</b>                                                                                                         | <b>SERVICE</b> |
| <b>Period of Residency Program Year:</b><br><br><b>From:</b> _____<br><br><b>To:</b> _____                                                                                             | <b>BREAKDOWN OF COMPENSATION:</b><br>Salary Rate: _____<br><br>Chief Resident: _____<br><br>Living Out Allowance: _____<br><br>Total: _____ |                |

## INDIVIDUAL HOUSE STAFF CONTRACT

1. This Individual House Staff Contract is subject to the Rules and Regulations of the New York City Health and Hospitals Corporation (the "Corporation") and the provisions, terms and conditions of the agreement which has been reached or which may be negotiated between the City of New York, the New York City Health and Hospitals Corporation, and the certified collective bargaining representative of these titles.
2. In the event of any inconsistency between this Individual House Staff Contract and the collective bargaining agreement, the collective bargaining agreement shall take precedence unless the collective bargaining agreement authorizes such inconsistency.
3. I shall remain employed by (facility): \_\_\_\_\_ for the full period of service except for the period of time I am employed by an affiliate hospital in accordance with paragraph 4 below unless terminated or suspended from service by the Corporation pursuant to applicable disciplinary procedures as contained in the applicable collective bargaining agreement.
4. The residency rotation for the period of this Contract will be in accordance with the applicable Residency Review Committee program standards, policies, and guidelines. In fulfillment of the residency training requirement a House Staff Officer may be required to perform services in another hospital and may be employed by a non-Corporation hospital.
5. I shall provide the clinical department and the facility Personnel Department with originals of my medical, dental or osteopathic school diploma; dental permit, if applicable; a letter from the dean of the school, a valid ECFMG or FMGEM certificate and appropriate visa, if applicable; and any other information required by the New York City Health and Hospitals Corporation no later than four (4) weeks prior to the commencement of service. I understand that it is my responsibility to have any written communications translated to English. Further, the translator shall execute a notarized statement swearing that he or she has read the particular document(s) and that his or her written English translation is a true and accurate statement of same. In exceptional circumstances the Executive Director or designee may waive, in writing, the time requirement but in no event may a housestaff officer be permitted to work without providing the Personnel Department with the original of the medical, dental or osteopathic school diploma; medical or dental license; dental permit, if applicable; a letter from the Dean of the school, a valid ECFMG or FMGEM certificate and appropriate visa, if applicable, and any other documents deemed appropriate by the Corporation. All other documents required by the Corporation shall be provided within four (4) weeks after the commencement of service.
6. I agree to accept all assignments of duty made by the Executive Director, the Clinical Department Chairman or their designee and shall perform my duties in a professional and satisfactory manner. I understand that moonlighting is prohibited during the PGY-1 year but is permitted, thereafter, only if in the opinion of the Chief of Service it does not impinge on my performance or educational obligations.
7. ~~It is understood that I have the choice of living in the hospital quarters provided for House Staff, if available, or of living out with a cash allowance in lieu of living in. It is further understood that when on duty, I have the use of an on-call sleeping accommodation provided by the hospital. If I choose the cash allowance, I will reside outside of the hospital and I agree to use the on-call sleeping accommodation only when I am or assigned on-call duty in the hospital.~~
8. I shall abide by the rules and regulations governing House Staff of the hospital and by any rules and regulations established by the New York City Health and Hospitals Corporation, Executive Director, Medical Board, State or Federal agencies during my period of service.
9. I agree that I shall complete the medical record of each patient for whom I have had primary medical responsibilities within three (3) days of the discharge or death of that patient. I further understand that I have the responsibility to complete any other required medical record(s) in a timely fashion. I understand that failure to comply with this provision may be cause for disciplinary action.
10. I agree to return all hospital and Corporate property to the hospital as of the last day of this individual contract unless my employment is continued and a new individual agreement is signed prior to the expiration of this contract. Failure to return hospital and Corporate property will result in the deduction of the replacement cost of the property from my paycheck.
11. The provisions of this Individual House Staff Agreement are only applicable when I am on the payroll of the New York City Health and Hospitals Corporation.
12. I, the undersigned, represent and warrant that I have read and understand the information contained herein and do hereby agree to accept the terms shown above.

Date: \_\_\_\_\_ (Signed) \_\_\_\_\_ ☐ DDS ☐ DMD ☐ MD  
☐ DO

Resident

**I have reviewed this Individual House Staff Contract and recommend same to the facility.**

Date: \_\_\_\_\_ (Signed) \_\_\_\_\_ ☐ DDS ☐ DMD  
☐ MD ☐ DO

Chief of Service **Credential Verification:**

Date: \_\_\_\_\_ Title: \_\_\_\_\_ (Signed) \_\_\_\_\_

**Approved:**

Date: \_\_\_\_\_ (Signed) \_\_\_\_\_

Executive Director/Designee

SAMPLE