

# Valley Baptist Medical Center School of Vocational Nursing

## Application Checklist

Name: \_\_\_\_\_ Application Due: **Monday, October 9th by 12:00pm**

Interview Date: October \_\_\_\_\_, 2024 at \_\_\_\_\_.

**My initials indicate I have submitted the following documents required: (NA – if not applicable)**

\_\_\_\_ Completed Application

\_\_\_\_ Current TEAS Scores (see Pre-entrance packet for criteria)

\_\_\_\_ Are you a VMBC Employee or Cerner user? Circle **YES** or **NO**

If **Yes**, Where: \_\_\_\_\_

Cerner User Name: \_\_\_\_\_

Employee ID number: \_\_\_\_\_

\_\_\_\_ Valid Photo Identification (Driver's License)

\_\_\_\_ Copy of Visa/Resident alien card (for non-United States citizens)

\_\_\_\_ DD-214, Certificate of Eligibility, and Military Transcripts (if using VA benefits)

\_\_\_\_ Form Signed Disclosure

\_\_\_\_ Confirmation of Background Check (check one)  Printed scheduled appointment

Blue postcard stating "Cleared"  Letter of Clearance from the TBON and Court Document(s)

\_\_\_\_ Form Record of Previous Education and Training (CSC – 010)

\_\_\_\_ Copy Secondary Education (check one)

Official High School transcripts \*\*  Official GED scores  Official GED scores and HS transcripts

\_\_\_\_ Post Secondary Transcripts

\_\_\_\_ Completed interview questions

\_\_\_\_ Completed Essay

\_\_\_\_ Two (2) letter of Recommendations

\_\_\_\_ Form Parking Permit

\_\_\_\_ Form W-9

\_\_\_\_ Form Stark II

\_\_\_\_ Copy of Immunization records

\_\_\_\_ Copy Basic Life Support Card

\_\_\_\_ **I understand** the Application and all required documents listed above are due Oct 9th by 12:00pm, and if any documents are missing or incomplete may jeopardize my acceptance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



# Application for Admission

Read all information and instructions before completing application.

**Print all information in BLACK ink or type.**

Legal Name – *Must be the exact name that appears on the Social Security Card.*

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Maiden \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_  
No. and Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

Email address: \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Are you a U.S. citizen?  Yes  No, Foreign Applicants: must submit a copy of Permanent Visa/Resident Alien card

Are you a U.S. veteran?  Yes  No **If using VA benefits: must submit DD-214, and Military transcripts.**

Have you ever applied/attended any Nursing Programs (RN / LVN)?  Yes  No

Programs: \_\_\_\_\_ Dates Attended: \_\_\_\_\_

Reason for disenrollment: \_\_\_\_\_

Are you licensed, certified, registered in any area?  Yes  No (this does not include Driver's licenses)

Licensed, certified, registered \_\_\_\_\_ Renewal Date: \_\_\_\_\_

Program Attended \_\_\_\_\_ State Licensure / Number \_\_\_\_\_

Employer \_\_\_\_\_ Dates of Employment \_\_\_\_ to \_\_\_\_ or currently

Address \_\_\_\_\_ Supervisor \_\_\_\_\_

Job Title \_\_\_\_\_ Job duties \_\_\_\_\_

Employer \_\_\_\_\_ Dates of Employment \_\_\_\_ to \_\_\_\_ or currently

Address \_\_\_\_\_ Supervisor \_\_\_\_\_

Job Title \_\_\_\_\_ Job duties \_\_\_\_\_

Employer \_\_\_\_\_ Dates of Employment \_\_\_\_ to \_\_\_\_ or currently

Address \_\_\_\_\_ Supervisor \_\_\_\_\_

Job Title \_\_\_\_\_ Job duties \_\_\_\_\_

Employers/Supervisors may be contacted. I, \_\_\_\_\_ give permission to release any confidential information regarding my employment.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date



**You must read this carefully as your signature indicates you understand and accept the conditions noted below: (For further information on licensure eligibility, go to: <http://www.bon.state.tx.us/exam-eligibility.htm>, Board Rules and Regulations, 213.28 – Licensure of Persons with Criminal Convictions)**

The Texas Board of Nursing (TBON) and Valley Baptist Medical Center (VBMC) are committed to providing safe care to those individuals in need of health care. Due to strict qualifications for licensure set forth by the TBON and policies on employment by Valley Baptist, you are required to submit to a Criminal Background check by assigned deadline. If the background check reveals any information, the results will be referred to Human Resources to determine eligibility for hire and possibly to the TBON for an opinion on probability for licensure.

The TBON, in compliance with the authority granted by the Texas Legislature, may refuse to approve persons to take the licensure examination who have been convicted of or received a deferred disposition for a felony, a misdemeanor involving moral turpitude, or engaged in conduct resulting in the revocation of probation.

Applicants must be able to answer "No" to the following questions in order to use the online licensure application. Other applicants may download a complete application packet. Review of applicants for licensure with eligibility issues can take three (3) to six (6) months to complete.

For any criminal offense, including those pending appeal, have you:

- A. been convicted of a misdemeanor?
- B. been convicted of a felony?
- C. pled nolo contendere, no contest, or guilty?
- D. received deferred adjudication?
- E. been placed on community supervision or court-ordered probation, whether or not adjudicated guilty?
- F. been sentenced to serve jail or prison time? court-ordered confinement?
- G. been granted pre-trial diversion?
- H. been arrested or have any pending criminal charges?
- I. been cited or charged with any violation of the law?
- J. been subject of a court-martial; Article 15 violation; or received any form of military judgment/punishment/action?

**(You may only exclude Class C misdemeanor traffic violations.)**

**NOTE: Expunged and Sealed Offenses:** While expunged or sealed offenses, arrests, tickets, or citations need not be disclosed, it is your responsibility to ensure the offense, arrest, ticket or citation has, in fact, been expunged or sealed. It is recommended that you submit a copy of the Court Order expunging or sealing the record in question to our office with your application. Failure to reveal an offense, arrest, ticket, or citation that is not in fact expunged or sealed, will at a minimum, subject your license to a disciplinary fine. Non-disclosure of relevant offenses raises questions related to truthfulness and character.

**NOTE: Orders of Non-Disclosure:** Pursuant to Tex. Gov't Code § 552.142(b), if you have criminal matters that are the subject of an order of non-disclosure you are not required to reveal those criminal matters on this form. However, a criminal matter that is the subject of an order of non-disclosure may become a character and fitness issue. Pursuant to other sections of the Gov't Code chapter 411, the Texas Nursing Board is entitled to access criminal history record information that is the subject of an order of non-disclosure. If the Board discovers a

criminal matter that is the subject of an order of non-disclosure, even if you properly did not reveal that matter, the Board may require you to provide information about that criminal matter.

- *Are you currently the target or subject of a grand jury or governmental agency investigation?*
- *Has any licensing authority refused to issue you a license or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, refused to renew a license, certificate or multi-state privilege held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?*
- *Within the past five (5) years have you been addicted to and/or treated for the use of alcohol or any other drug?*
- *Within the past five (5) years have you been diagnosed with, treated, or hospitalized for schizophrenia and/or psychotic disorder, bipolar disorder, paranoid personality disorder, antisocial personality disorder, or borderline personality disorder?*

I understand that as a student of the health care profession I must be able to perform a number of physical activities in the clinical portion of the program. At a minimum, I will be required to lift patients, stand for several hours at a time, and perform bending activities. If I have a chronic illness or condition I must be able to (maintain current treatment) and be able to implement direct patient care. The health care education experience also places students under considerable mental and emotional stress as they undertake responsibilities and duties impacting patients' lives. I must be able to demonstrate rational and appropriate behavior under such stressful conditions. [Individuals should give careful consideration to the mental and physical demands of the program prior to the school making the final candidate selections.]

In consideration of processing my Application for Admission, I grant permission and consent to request from any person, any and all information pertinent to my application for admission. I authorize the Valley Baptist Medical Center Vocational School of Nursing and its agents and employees to obtain and acquire any information necessary to process this application, and recognize that Valley Baptist LVN School will rely upon information it obtains. I fully release and discharge Valley Baptist LVN School and its agents and employees for their reliance on any such information obtained (including expenses, court costs, attorney fees, payment of claims and judgments), and hereby release and hold harmless from any liability or loss whatsoever.

I understand falsification of any records or documents submitted in the admission process are grounds for denial of admission to the school.

I have provided true, correct, and complete information on my application. I have read and understand the information presented in the application packet.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Proof of Criminal Background Clearance

I, \_\_\_\_\_, understand according the Student Handbook each applicant must complete a (SAFRAN) MORPHOTRUST USA Criminal Background Check (CBC) and must be cleared by the Board of Nursing prior to enrollment in the program.

### Attach Confirmation of Background

- Printed Scheduled appointment – student is responsible to submit clearance documentation once received
- Blue postcard from the Board of Nursing stating Clearance
- Outcome letter from the Board of Nursing and Court Documents





**Texas Workforce Commission – Career Schools and Colleges Record of Previous Education and Training**

**Authority for Data Collection:** Texas Education Code, §132.026, §132.055 and Texas Administrative Code, §807.122(e)(7), §807.191(c)

**Planned Use of the Data:** This form must be used by the school in its entirety to provide a record by which previous education and training may be evaluated, and credit given to the student and to provide a record of such credit and reduction of program length/cost as required by the law.

**Instructions:** Complete each item on front and back. If an item is not applicable, write “NA.” If credit is being claimed for post-secondary education, a transcript must be provided. Credit for experience should also be granted, if justified by the school’s evaluation of the student’s skills. Attach additional pages as needed. The completed form is to be maintained in each student’s file. A copy of the completed form will be given to the student. Credit for previous education and training cannot be granted until this form is completed and signed by the school official and the student. If clarification is required, contact Career Schools and Colleges.

**School Information**

School Number: S4099

School Name: Valley Baptist Medical Center School of Vocational Nursing

**Student Information**

Name: \_\_\_\_\_

SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

Date of Birth (mm/dd/yy): \_\_ / \_\_ / \_\_

Name of Program: Vocational Nursing

Secondary Education:  High School Diploma

Home Schooled

GED

**Post-secondary Education**

Type of School:  College or University  Technical or Vocational  Other \_\_\_\_\_

Name and Location of School: \_\_\_\_\_

Dates Attended (MM/YR): From \_\_\_/\_\_\_/\_\_\_ To \_\_\_/\_\_\_/\_\_\_

Graduated:  YES  NO

Type of Diploma/ Degree: \_\_\_\_\_

Major Field of Study: \_\_\_\_\_

**Military Education**

Military Occupational Specialty and Program of study (CIP Code):

Military Experience Education or Training:

Program Hours:

Credited Hours:

Proof of Military Education provided:

Justification for not awarding military credit:

**Previous Education**

Identify previous experience and skills that relate to the program curriculum for which you desire credit.

FORM: CSC-010 REV1/23

## **For School Use Only**

Entrance Test Name and Version: ATI, TEAS Version 7

Score: See attached Individual Performance Profile

### **School Evaluation of Previous Education and Training**

List below the subjects of this program for which credit is given, the hours of credit granted, and the justification for which the credit is granted such as skills tests, years' experience, and transcript information.

Subject:

Course Time \* Hours of Credit:

Justification of Credit:

### **Credit / Price Adjustments**

Original Program Length (Hrs):	Original Cost (Tuition): \$	Other \$	Total: \$
Less Credit Granted (Hrs*):	Less Credit Granted (Tuition):(\$ )	Other: \$	Total: \$
Adjusted Program Length (Hrs)*:	Adjusted Cost: \$	Other: \$	Total: \$

\*Course Time \* Course Time (actual hours): the total hours of time experienced by the student in the course for all types of of course time, including classroom, lab and externship hours. An hour of course time is equivalent to a 50-minute to 60-minute lecture, recitation, class (including a laboratory class or shop training) or internship, within a 60-minute period, or 60 minutes of preparation in asynchronous distance education. Intensity of course time hours vary by school and program, but typically, 100 course time hours is equivalent to about a month of full-time school.

### **School Official Acknowledgment**

I certify that all information provided by the student has been evaluated and that the student will not receive credit.

I certify that all information provided by the student has been evaluated and that the student has been given credit for which he/she is entitled as identified herein.

Signature of Authorized School Official: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date (mm/dd/yy): \_\_/\_\_/\_\_

### **Student Acknowledgment**

**Do not sign below unless the information above is complete and signed by the school official.**

I have discussed the above evaluation of my previous education and training with the authorized school official and acknowledge that:

I will receive the above stated credit, or

I will not receive credit.

Printed Name of Student: \_\_\_\_\_

Signature of Student: \_\_\_\_\_

Date (mm/dd/yy): \_\_/\_\_/\_\_

Individuals may receive and review information that TWC collects about the individual by emailing to [open.records@twc.state.tx.us](mailto:open.records@twc.state.tx.us) or writing to TWC Open Records, 101 E. 15th St., Rm. 266, Austin, TX 78778-0001.  
FORM: CSC-010 REV1/23

NAME: \_\_\_\_\_

Date: \_\_\_\_\_

## 2024 - INTERVIEW QUESTIONS - Potential Candidate for Admission

Clearly enter your statement below for each question or scenario.

### **PREPAREDNESS FOR STUDENT ROLE:**

1. Tell me about yourself (where are you from, family, college courses, any hobbies, community involvement or organizations belong to, etc.).

2. Do you plan on working during school?

If yes, where and how much will you work per week?

Where: \_\_\_\_\_ How much per week: \_\_\_\_\_

3. Do you have any medical experience?

4. Do you have dependable transportation, especially for clinical rotations? (Most of our clinical rotations are here at Valley Baptist, however, there are a few that are off campus, and even in Brownsville).

Tell us, how you will get to school if your car breaks down, you have a flat tire, or you have some other problem with your vehicle. (Back-up plan)

5. Tell us a bit about your finances. How you will pay for school?

Amount Saved or range: (Tuition and Fees \$12,200)

- Less than \$3,050
- \$3,050 - \$6,100
- \$6,100 - \$9,150
- More than \$9,150
- Full amount \$12,200

What if this resource does not last the whole year, what will you do? (Unplanned or emergency expenses)

6. What type of support system is available for you?
  
7. Why have you chosen this particular nursing school? Have you applied to any other programs?
  
8. Tell us why you think you would be the **best** candidate for our nursing program?

### **GOALS**

9. What is your proudest achievement in your life to date?
  
10. What has been the most challenging thing in your life so far?
  
11. In regards to nursing, where do you see yourself in 5 years?

### **NURSING**

12. Tell us why you would like to become a nurse?
  
13. What qualities do you think a good nurse should possess?
  
14. What kind of experiences have you had with nurses in your past?

## **ACADEMICS**

15. Tell us about your study habits and how do prepare for class and for exams?
  
  
  
  
  
  
  
  
  
  
16. What would you do if you find yourself struggling in a nursing course?
  
  
  
  
  
  
  
  
  
  
17. What is the type of educator/supervisor you like the most? Why?

## **PRIORITIES**

### **NEW INTERVIEW:**

18. While in school, you are expected to prepare each evening by reading and studying, 2-4 hours on average. You will have 2 (two) tests per day some days and at least 1 (one) per day. You are expected to arrive early to clinical, sometimes by 5:30 am. Tell us about your responsibilities at home (spouse, significant other, children, cleaning, cooking, taking care of someone, etc.) and how you will balance these with the added responsibility of school.
  
  
  
  
  
  
  
  
  
  
19. What sacrifices do you think you will need to make to be successful in this program?

### **RETURNING STUDENT:**

20. What has changed since you were in this program?

What do you think contributed to your not being successful?

What will you do differently to succeed this year?

**PERSONAL PERSPECTIVE**

20. What are your personal strengths?

21. What are your personal weaknesses?

22. What would your previous bosses or classmates say about you?

23. Do you see yourself as a leader, a follower, or a loner?

Why do you think that?

24. In the past, how have you dealt with anxiety or a stressful situation?

**CONFLICT RESOLUTION:**

25. What would you do if you caught a classmate in a dishonest situation, such as cheating, fabricating or plagiarizing?

26. What would you do if you have a conflict with an instructor?

27. A nurse or a student at a clinical site is seen doing something that could potentially cause harm to a patient. What would you do and why?
28. You are reporting an important change in one of your patient's condition to a doctor and the doctor yells at you and calls you stupid. What would you do?
29. Do you have any questions for us?

**NOTE TO STUDENTS:**

- We do not advise any planned events, celebrations, or anything like this that might come up during the school year, or anything that may interfere with your study or student requirement. (Travel, weddings, etc.)
- In addition, we require our students to perform community service activities. They must perform 2 (two) activities per level and each activity must be at least 2 hours in length. We have three levels in our nursing program so that is at least 6 (six) activities per year.
- It is advised to have a wireless electronic device with internet connectivity with up-to-date software.





## Request for Taxpayer Identification Number and Certification

**Give Form to the  
requester. Do not  
send to the IRS.**

▶ Go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9) for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	<p><b>1</b> Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.</p>	
	<p><b>2</b> Business name/disregarded entity name, if different from above</p>	
	<p><b>3</b> Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only <b>one</b> of the following seven boxes.</p> <p><input type="checkbox"/> Individual/sole proprietor or single-member LLC      <input type="checkbox"/> C Corporation      <input type="checkbox"/> S Corporation      <input type="checkbox"/> Partnership      <input type="checkbox"/> Trust/estate</p> <p><input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____</p> <p><b>Note:</b> Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</p> <p><input type="checkbox"/> Other (see instructions) ▶ _____</p>	<p><b>4</b> Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):</p> <p>Exempt payee code (if any) _____</p> <p>Exemption from FATCA reporting code (if any) _____</p> <p><small>(Applies to accounts maintained outside the U.S.)</small></p>
	<p><b>5</b> Address (number, street, and apt. or suite no.) See instructions.</p>	<p>Requester's name and address (optional)</p>
	<p><b>6</b> City, state, and ZIP code</p>	
	<p><b>7</b> List account number(s) here (optional)</p>	

### Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

<b>Social security number</b>					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black; height: 20px;"></td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 25%; border: 1px solid black; height: 20px;"></td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 40%; border: 1px solid black; height: 20px;"></td> </tr> </table>		-		-	
	-		-		
<b>OR</b>					
<b>Employer identification number</b>					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; border: 1px solid black; height: 20px;"></td> <td style="width: 5%; text-align: center;">-</td> <td style="width: 70%; border: 1px solid black; height: 20px;"></td> </tr> </table>		-			
	-				

### Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign Here**

Signature of U.S. person ▶

Date ▶

### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to [www.irs.gov/FormW9](http://www.irs.gov/FormW9).

### Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
  - Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
  - Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
  - Form 1099-S (proceeds from real estate transactions)
  - Form 1099-K (merchant card and third party network transactions)
  - Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
  - Form 1099-C (canceled debt)
  - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.*



## STARK II ACTION REQUIRED

Vendor Name: \_\_\_\_\_ Vendor Number: \_\_\_\_\_ Facility Number: \_\_\_\_\_

Dear Vendor:

In order to ensure that Tenet Healthcare Corporation ("Tenet") and its subsidiaries and affiliates, including Conifer Health Solutions, LLC ("Conifer"), and all facilities owned and operated by Tenet ("Tenet Facility") comply with federal law concerning financial arrangements between physicians and entities that provide certain health care services, we require all vendors provide us with the following information.

For purposes of answering these questions, the following definitions apply:

**"Immediate family member"** means the following individuals: husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

**"Physician"** means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatric medicine, a doctor of optometry or a chiropractor.

1. Is your company owned in whole or part, directly or indirectly, by a physician who refers patients to or treats patients at any Tenet Facility or an immediate family member of a physician who refers patients to or treats patients at any Tenet Facility?  NO  YES
2. Is your company owned in whole or part, directly or indirectly, by any person (other than a physician or an immediate family member of a physician) who refers patients to any Tenet Facility?  NO  YES
3. Does your company employ or contract with a physician who refers patients to or treats patients at any Tenet Facility or an immediate family member of a physician who refers patients to or treats patients at any Tenet Facility? If "YES", please answer the following:
  - (i) Does the employed or contracted physician, or immediate family member of the physician, receive compensation from your company that is based on the volume/value of referrals to a Tenet Facility?  NO  YES
  - (ii) Does the compensation paid to the physician or the immediate family member of such a physician exceed fair market value for the service provided by such physician or immediate family members of such physician?  NO  YES
4. If you are entering into an arrangement as a vendor with Tenet, Conifer or any Tenet Facility as an individual, are you a physician who refers patients to or treats patients at any Tenet Facility or an immediate family member of a physician who refers patients to or treats patients at any Tenet Facility?  NO  YES

If you answered "Yes" to any of the questions (1-4) above, please indicate whether the physician/person is:  an owner,  an employee, or  contractor of the company and complete the following:

- (a) Name of Physician or other person who refers to the Tenet facility: \_\_\_\_\_
- (b) The name(s) of any Tenet Facility to which the physician or other person refers: \_\_\_\_\_
- (c) If applicable, the name of the physician's immediate family member(s) who have ownership in the company: \_\_\_\_\_

Thank you for your anticipated cooperation in providing this information.

Sincerely,

I represent that the answers provided herein are truthful and accurate as of the date of my signature below. I agree to immediately notify \_\_\_\_\_ of any changes in the above-disclosed information.

\_\_\_\_\_  
VENDOR Officer Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Title

11/26/13

**VBMC – HARLINGEN HOSPITAL- Parking Enforcement Fee Grid**

<b>VIOLATION</b>	<b>ENFORCEMENT FEE</b>
Failure to display decal	1 <sup>st</sup> offense is a ticket that signifies a warning 2 <sup>nd</sup> offense is a second ticket with enforcement fee of \$40.00 3 <sup>rd</sup> offense is a third ticket and \$80.00 enforcement fee
Parking in a handicap space without appropriate plates or placard	1 <sup>st</sup> Enforcement Fee of \$40.00 2 <sup>nd</sup> offense is a second ticket with enforcement fee of \$40.00 3 <sup>rd</sup> offense is third ticket with enforcement fee of \$80.00
Parking in reserved parking spaces such as "Volunteer" or "Expectant Mother" spaces.	1 <sup>st</sup> Enforcement Fee of \$40.00 2 <sup>nd</sup> offense is a second ticket with enforcement fee of \$40.00 3 <sup>rd</sup> offense is a third ticket with enforcement fee of \$80.00
Parking policy violation Ticket #1	Enforcement fee of \$40.00
Parking policy violation Ticket #2	Enforcement fee of \$40.00
Parking policy violation Ticket #3	Enforcement fee of \$80.00
Parking policy violation Ticket #4	Ticket fee of \$80.00 - subject to suspension of parking privileges on hospital property

**NOTE:** All tickets issued will be shared with employee's department leader and Administration. All employees are subject to disciplinary action, in addition to above stated enforcement fees for failure to follow parking procedures.



## Vehicle Parking Registration

Student Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Department: \_\_\_ LVN School \_\_\_\_\_

Phone Number: \_\_\_\_\_

Vehicle Information:

**Primary Vehicle:**

Make: \_\_\_\_\_ Model: \_\_\_\_\_ License Plate #: \_\_\_\_\_

**Alternate vehicle:**

Make: \_\_\_\_\_ Model: \_\_\_\_\_ License Plate #: \_\_\_\_\_

Will not be driving

1. I agree to display Student parking permit in a visible area
2. I agree to park in the designated Student parking
3. I understand that failure to comply with parking plan will result in being ticketed, fined, and lead to possible disciplinary action.

Student Signature: \_\_\_\_\_

**Office Use Only:**

Parking Permit Number: \_\_\_\_\_

Parking Permit Number: \_\_\_\_\_