LET’S GET STARTED
YOUR GUIDE TO REGISTRATION
DOCUMENT CHECK LIST:

ALL Required Documentation is Due One Month Prior to Visit

- Current Curriculum Vitae
- Statement from your institution giving you permission to travel and train at ATLAS
- A letter of Good Standing
- Health and Fitness Statement
- Copy of your Visa and Travel Documents
- Payment (Refer to Wire transfer information)
- Release Authorization Form

Once your paperwork has been returned and complete, you will receive an email of clearance from our department.
HEALTH & FITNESS STATEMENT
-- RESIDENTS / FELLOWS / STUDENTS / TRAINEES --

NOTE: Section 1 of this form must by completed by the trainee. Section 2 needs to be completed by your health care provider (or student health office) before you start your affiliation at RPCI.

1a. Fitness for duty: My signature at the bottom of this page attests, that to the best of my knowledge, except as noted below, I am free from physical or mental impairments, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior altering substances which might interfere with the performance of my duties or would impose a potential risk to patients or personnel. I understand the risks of infection in health care settings and the potential to prevent disease via vaccinations.

   I wish to disclose the following issues that might interfere with the performance of my duties:
   ☐ request to discuss with Employee Health staff

1b. Protection against Hepatitis B: Exposure to Hepatitis B virus constitutes a serious occupational health hazard to health care workers. A Hepatitis B infection is an unpredictable disease that may cause severe illness lasting weeks or months and lead to serious complications. Health care workers are at 20 times greater risk of contracting the virus than the general public; 18,000 health care professional contract Hepatitis B every year. In addition, almost 4,000 persons die from Hepatitis B related cirrhosis every year.

   Trainees in the health care fields are strongly urged to complete Hep B vaccination from their primary care physician or student health offices prior to starting clinical work. The vaccine against Hepatitis B is prepared from recombinant yeast cultures and is free of human blood or blood products.

Recommended groups for immunizations are: 1) Physicians and surgeons, dentists, oral surgeons and dental hygienists; 2) Nurses and other hospital personnel providing direct patient care and who frequently handle blood and other body fluids; 3) Laboratory staff in clinical labs or research labs handling blood/body fluids, and 4) trainees in any of these groups.

☐ Although I may have occupational exposure to Hepatitis B, I wish to decline the vaccine at this time. I understand that as a consequence of my occupational duties/training, I am at risk of contracting Hepatitis B, leading to potential long term health problems and even death. I decline to be vaccinated at this time.

☐ I have had Hepatitis B or am known to be positive for the antibody to the core antigen for Hepatitis B.

☐ I have previously received the vaccine and have proof.

1c. Health care workers/trainees with direct patient contact: Persons with direct patient contact are strongly encouraged to receive annual influenza (flu) vaccines to reduce the risk of becoming ill and to reduce transmitting infection to patients, co-workers and families. A one time booster dose to Tetanus, diphtheria and acellular pertussis (Tdap) vaccine is also recommended if it has been longer than 2 years since the last Td booster. Talk with your doctor about these vaccines.

   Signature ________________________ Date ________________________

Print Name __________________________ date of birth __________________________

CONTACT INFO: phone _____ - _____ - ___________ e-mail __________________________

***continue to next page →***
2. **INSTRUCTIONS:** Proof of immunization must be provided. Any vaccines given before 1968 must be proven to be live vaccine without gamma globulin. All dates should be recorded on this form and include month, date and year. Please type or print.

**A. REQUIRED:** Measles (Rubeola) Immunity. Must have one of the following:
1) TWO dates of Measles Immunization (1)_________________(2)________________________
   Both must be given after 1967 and on or after the first birthday.
2) Date of Measles Titer_________________________ and Result__________________________
3) Date Physician Diagnosed Measles___________________________________________________

**B. REQUIRED:** Rubella (German Measles Immunity). Must have one of the following:
1) Date of one Rubella Immunization after the first birthday______________________________
2) Date and result of Rubella Titer____________________________________________________
   *History of this illness is not acceptable

**C. REQUIRED:** Mumps Immunity. Must have one of the following:
1) Date of one Mumps Immunization___________________________________________________
2) Date and result of Mumps Titer____________________________________________________
3) Date Physician Diagnosed Mumps__________________________________________________

**D. REQUIRED:** CHICKENPOX Immunity. Must have one of the following:
1) Dates two VZV Immunization 1) ___________________ 2) _____________________________
   OR 2) Date Physician diagnosed Chickenpox / zoster [circle one] _______________________
   OR 3) Date and result of Varicella titer ______________________________________________

**E. REQUIRED:** Tuberculin Skin Test (PPD) within the past year.
   Date: ___________________________ Result: ___________________________
   *If positive, please provide documentation of CXR or completion of treatment.

**F. Hepatitis B vaccine:** required for patient contact or if working with human tissue.
1) ___________________ 2) ___________________ 3) ___________________
   OR 2) Date of HBsAb Titer_________________________ and Result: ______________________
   OR 3) Hep B vaccine declined

**G. REQUIRED:** Influenza Vaccination Date ___________________________ (required if at RPCI between November 1st and April 1st)

The above information has been reported by:

[Signature] [Date]

[Print Name]

**Physician/Organization Name:**

[______________________________]

**Address:**

[__________________________________________________________________________]

**City/State/Zip Code:**

[_________________________]

**Telephone #:**

[_________________________]

*Completed forms can be returned via mail or fax to:

  Educational Affairs
  Roswell Park Cancer Institute
  Elm & Carlton Streets
  Buffalo, NY 14263
  Telephone 716/845-2339
  FAX 716/845-8178

07/13/12
I authorize Roswell Park Cancer Institute (RPCI) to produce, use, disclose, display and/or reproduce, in color or otherwise, feature stories, articles, photographic portraits, pictures or videotapes of me, including still, single, multiple or moving, in which my voice, quotes by me, all or parts of my face or body appear ("the Photograph/Article") and to modify, disclose or use a portion or portions of such Photograph/Article, alone or with any other photographic, audio, artistic or written information, including ______________ ____________________, for the following purposes:

To be used in Institute publications including but not limited to brochures, newsletters, magazines and websites and in other marketing materials including but not limited to newspaper and magazine articles, television and radio advertisements, and postings on internet and photosharing websites (e.g. flickr.com).__________

I understand that I have a right to revoke this authorization at any time by presenting my written revocation to the Health Information Management Department. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

________________________________________________________________________

If I fail to specify an expiration date, event or condition, this authorization will expire in five years.

I understand that authorizing the disclosure of this information is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment at RPCI. I understand that I may inspect or copy the written information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for re-disclosure and the information may then not be protected by Federal confidentiality rules. I acknowledge and agree that any photograph, videotape, publication and/or negatives and other descriptive material connected therewith created by RPCI pursuant to this Authorization shall be and remain the property of RPCI. RPCI will not receive compensation for using/disclosing information as authorized herein.

If I have questions about disclosure of my health information, I may contact the Privacy Officer or the Health Information/Medical Record Department at 845-5990.

Signature: ____________________________ Date: ____________

Print Name: ____________________________________________

Parent/Guardian Signature: ____________________________ Date: ____________

Telephone Number: ____________________________________

Mailing Address: _______________________________________

E-mail Address (optional): _______________________________
PAYMENT INFORMATION:

Bank Name  
HSBC Bank, USA

Address  
One HSBC Center  
18th Floor  
Buffalo, New York 14203

Manager  
Jacalyn M. Baker

Phone Number  
(716) 841-2580

SWIFT Code  
MRMDUS33

ABA Number  
022000020

HRI Account Number  
772-00090-5

HRI Account Type  
Checking Account

Beneficiary Name:  
Health Research, Inc.

Put invoice # on wire transfer information. Notify HRI Business Manager of the invoice # and amount transferred.

Edith J. Troy
HRI Business Manager
ejt04@healthresearch.org
(716) 845-2311

please cc Allison.Polakiewicz@RoswellPark.org
716-845-8227
ACCOMMODATIONS

Roswell Park Cancer Institute (RPCI) does not provide housing for trainees. Please find below links to websites offering housing in the Buffalo area. RPCI is located in downtown Buffalo (see http://www.buffalocvb.org/Buffalo_Niagara_map.pdf) and is on a Metro line that runs the length of Main Street.

ATLAS recommends the following locations for short term accommodation

Kevin’s Guest House
(0.3 mile from RPCI, ~6 minute walk)

782 Ellicott Street,
Buffalo, NY
(716) 882-1818
www.kevinguesthouse.com

Double Tree Club Hotel
(connected to RPCI)

125 High Street,
Buffalo, NY
(716) 845-0112

Lenox Hotel and Suites
(0.8 mile from RPCI, ~16 minute walk)

140 North Street,
Buffalo, NY
(716) 884-1700 or 1-800-82-LENOX
www.lenoxhotelandsuites.com

The Lenox Hotel and Suites are in walking distance of the RPCI Medical Campus. They also offer an extended stay option for relocation or temporary assignments.
FLIGHT INFORMATION

Please make sure that you are arriving into Buffalo Niagara International Airport (BUF). There are also direct flights into Buffalo from Toronto Pearson International Airport, if your visa permits. We recommend taking a local shuttle.

Buffalo Airport
http://buffaloairport.com/

Toronto Airport
http://www.torontopearson.com/#

TRANSPORTATION

The Buffalo Niagara International Airport offers several ground transportation options including rental cars, transit and taxi services. Visit http://buffaloairport.com/Ground/ for more information.

Other transportation service contacts in Buffalo:

AAA Taxi Tour & Shuttle – (716) 550-0550
AA Taxi Transportation Inc. – (905) 321-3206
Liberty Yellow Cab – (716) 877-7111