Catholic Health Initiatives

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SJH/SJE/SJB

Medical Staff Services

Advanced Practicum and Medical Student Requirements and Expectations

This document outlines the process for Advanced Practice and Medical Students to be approved to engage in a clinical hands-on education experience at CHI Saint Joseph facilities under the supervision of a preceptor on the SJH/SJE/SJB Medical Staff. This document will detail the student requirements as well as the expected delivery of the requirements within the specified time range.

The Requirements

To be eligible to participate in a clinical education experience, a student must submit all required documentation.

- **Photograph**
- **Current Immunizations**
  - Negative Tuberculin skin test or negative chest x-ray within past year
  - An immunization record of MMR indicating positive history or titer
  - Proof of Hepatitis B vaccine , or documentation of initiation of Hepatitis B vaccine, or a declination/waiver form
  - Proof of current flu vaccine – during flu season
  - Such other immunizations/vaccines as required by applicable Hospital policies
- **Driver's License**
- **Current professional liability Insurance face sheet in amounts and with a carrier acceptable to the hospital ($1/3 million and with a current A. M. Best financial ratings of B+ or better). If UKMC insurance, it must show Saint Joseph Health System as a rider.**
- **Letter of Good Standing from the Institution**
- **CISIVE Background Release Form**

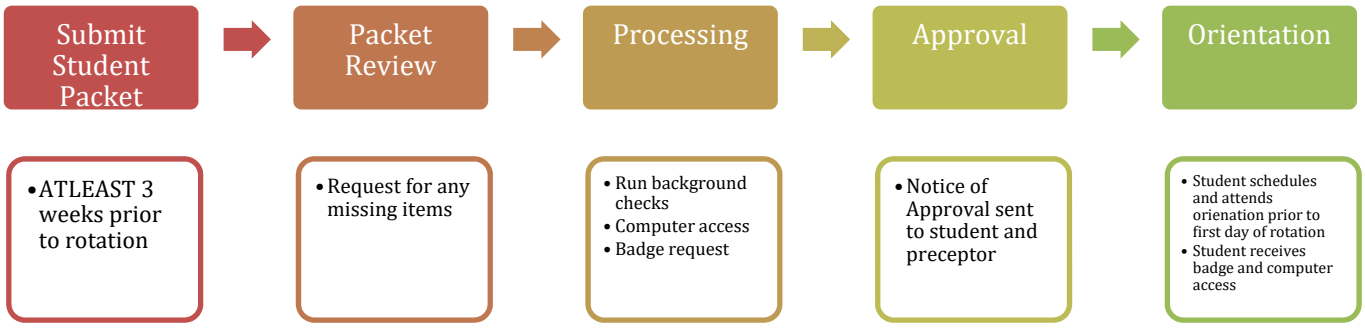
Requirements continued on next page.

- **Completed Hospital Confidentiality Agreement (in packet)**
- **Completed Confidential Computer Access Agreement-Exhibit B (in packet)**
- **APPENDIX A – Educational Opportunities**
- **Statement of Agreement**
- **Preceptor Indication of Student EHR Access (in packet)**
- **Completed Student Packet (please submit as one PDF file)**

Students who do not follow the approval process of the Medical Staff Office will not be permitted to rotate in our facilities. The student, university contact, and preceptor will receive an approval email for the student with the start date. Having the student in our facilities without the proper approval is a liability for both parties, and can jeopardize the agreement with the institution.

The Process

The Medical Staff Office's process for approving students for clinical rotations is outlined in the flow chart below.



Revised: 12/15/2023

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Medical Staff Services

All students who receive computer access **must** attend a short orientation (approx. 30 mins) before rotating in our facilities. Orientation can typically be provided on the day that the student starts, but that is not always possible so the student will be expected to plan ahead and coordinate with the Medical Staff Office.

The Expectation

To comply with the ***Medical Staff Policy Regarding Educational Opportunities (Students)***, any advanced practicum and/or medical student must first obtain approval from the Medical Staff Office before rotating at SJH/SJE/SJB.

- In order for the student to participate in a clinical education experience, all requirements must be returned at least **3 weeks prior** to the start date of the clinical rotation. No exceptions. If we do not receive **all** of the requirements three weeks ahead of time, the student's start date will be pushed back.
- If computer access is not needed, all requirements must be returned at least **2 weeks prior** to the start date of the clinical rotation.

If the requirements are not submitted by the due date, the student will be need to reschedule their rotation to a later date.

Multiple Rotations

Each individual rotation must be approved by the Medical Staff Office before rotating, regardless if the student rotated in our facilities prior.

If the student is coming back for multiple rotations, they must notify the Medical Staff Office of the upcoming rotation by submitting the clinical rotation form at least **1 week prior** to the start date of the clinical rotation. This notice is essential to confirm access is in place:

- Re-activate Student Badge
- Re-activate Computer Access, if needed

Questions or Concerns, please contact the following Medical Staff Services Contact:

Meggan Carr
Medical Staff Coordinator
Medical Staff Services
859-313-1273
meggan.carr@commonspirit.org

Revised: 12/15/2023

Status **Active** PolicyStat ID **11178091**

Effective	03/1992
Last Reviewed	05/2022
Last Revised	05/2022
Next Review	05/2025

Owner	Sheila Griffeth: Market VP Cardiovascular, Stroke, & Surgical Svs
Folder	Surgery
Applicability	SJHHospital-SJHBerea-SJHEast

Visitors in the O.R.

Purpose:

A. To define qualifications & requirements of individuals who observe or visit the O.R. Suite.

B. All persons entering the facility must don a surgical mask upon entry. This requirement extends to the perioperative area per the current COVID KY Market Policy (linked here.)

Policy:

A. It is the policy of St. Joseph Hospital Perioperative Services that all people coming to the OR to observe must go through Human Resources, extension 1768.

B. The following persons are permitted in the operating room as visitors or observers with permission from the Director of Surgery/Designee, the Anesthesiologist and Surgeon who are providing care to the patient.

C. All who visit or observe must adhere to all the restrictions of this policy.

1. Invited health care providers or health care students.
2. Invited sales or equipment representatives who will contribute to the management of the patient's care.
3. Administrative, management, and maintenance personnel employed by this hospital.
4. High School and college students or other professionals who are part of a **formal, hospital approved program sponsoring surgical observation opportunities**. Student observations must be related to an interest in a health related profession.
5. All observers must be 18 years old and above to observe in the OR.

D. The following criteria must be met for all observers *not* employed by or affiliated with Saint Joseph Hospital.
    1. Documented completion of an O.R. orientation (or its equivalent) which includes:
        a. Understanding of operating room decorum
        b. Actions he/she must take if faintness or queasiness develops during the observation experience
        c. Maintenance of patient confidentiality
    2. Observers, except physicians with privileges, will not gown or glove.
    3. Visitors will not physically participate in patient care.
    4. Observers must sign a confidentiality statement in volunteer services before coming to the OR.
    5. Observers must have a current tuberculosis test within the past 12 months and provide a copy of this document to human resources before coming to the OR.
    6. Proof of vaccination status will be requested to be filed with Human Resources prior to allowing visitation in the operating room, please see section D, line 'a' for a list of required vaccinations.
    7. Once these steps are complete in Human Resources please contact the Educator for the Surgery Department to schedule a date to observe in the OR. At that time, an OR orientation will be scheduled and documented.

E. Documentation
    1. All visitors/observers will be documented on the O.R. Data Record if present during the intraoperative phase.
    2. Please refer to the following policies regarding vaccination via the Employee Health Kentucky Market/CommonSpirit Guidelines
        a. Employee Vaccinations for specifics on each type of vaccine and implications for being on campus/ in the facility (covers employees as well as visitors in the operating room as defined above.)

References:

A. AORN. (2022). *Perioperative Standards and Recommended Practices.*
B. AORN. (2022). *Perioperative Standards and Recommended Practices.*

Approval Signatures

Step Description	Approver	Date

Sheila Griffeth: Market VP Cardiovascular, Stroke, & Surgical Svs	05/2022
Lewis Perkins JR: VP Patient Care Services	03/2022
Evelyn Fugate: OR Mgr	03/2022
Evelyn Fugate: OR Mgr	02/2022

Status **Active** PolicyStat ID **12880426**

Effective	08/2021
Last Reviewed	12/2022
Last Revised	08/2021
Next Review	12/2023

Owner	Marsha Burke: Dir-Medical Staff Services
Folder	Medical Staff Services
Applicability	Central East Market (includes CHI SJH Market, CCH, FLAGET, SJB, SJE, SJH, SJJ, SJL, SJMS)

Medical Staff Policy Regarding Educational Opportunities (Students)

Saint Joseph Hospital/Saint Joseph East/Saint Joseph Berea

Medical Staff Policy

TITLE: Medical Staff Policy Regarding Educational Opportunities "Students"	SECTION: CREDENTIALING	
	SUPERCEDES:	CODE: 091-CRE-130

PURPOSE:

This Policy relates to instances in which medical students, podiatric students, dental students, psychology students, student physician assistants, or student advanced practice registered nurses (hereinafter collectively referred to as "Students") come to the Hospital to participate in patient care activities under the guidance and direct supervision of a Preceptor, as that term is defined herein, and/or to observe Hospital operations or treatment of patients by Practitioners or APCs for education and

training purposes.

The Hospital is not a teaching hospital; and, therefore, does not have a formal program for the training of Students. However, the Hospital does permit Students to participate in a clinical education experience at the Hospital under the limited circumstances set forth within this Policy.

Pre-medical students and residents are **not** addressed by this Policy.

REQUIREMENTS APPLICABLE TO STUDENTS:

Preceptor. A Preceptor is defined as a Practitioner (*i.e.,* a Physician, Dentist, or Podiatrist) who has, as applicable, a Medical Staff appointment and Clinical Privileges at the Hospital or an APC (*e.g.,* a Physician Assistant or Advanced Practice Registered Nurse) with Clinical Privileges at the Hospital such that the Preceptor is qualified to supervise the Students with respect to the patient care activities the Students are, or will be, observing or participating in at the Hospital.

In order to act as a Preceptor for a Student, the Practitioner or APC must be providing preceptor services in the clinical area in which the Practitioner or APC has Privileges. All Preceptors must designate an alternate Preceptor who must meet the same qualifications as the designated Preceptor and who has agreed, in writing, to act as backup for the designated Preceptor in the event the designated Preceptor is unable to perform his/her duties at any time for any reason. In such event, the alternate shall have the same responsibilities as the Preceptor.

Direct Supervision. Students participating in a clinical experience at the Hospital shall, at all times, be under the direct supervision of an assigned Preceptor. Direct supervision means that the Student is in the immediate presence of his/her Preceptor when the Student is observing, performing, or otherwise participating in patient care activities.

Documentation/Countersignatures. A Student holds no license and has no legal status as a provider of health care services. A Student is not a licensed independent practitioner for purposes of the Centers for Medicare & Medicaid Services (CMS) Hospital Conditions of Participation or pursuant to accreditation standards.

A Student's participation in patient care activities for educational purposes shall be documented in the medical record in accordance with applicable laws, rules, and regulations.

Patient Notification and Consent. The Preceptor shall inform the patient (or the patient's legal guardian or authorized representative) of the presence of a Student and obtain the patient's permission prior to any activity involving the patient in which the Student will be involved (whether by observation or action). In the event that the patient, for any reason, refuses Student involvement, then the Student shall not participate in the care of the patient. The Preceptor and the Student shall, at all times, observe and respect the privacy rights of the patient as well as the patient's absolute right to refuse the Student's participation in the patient's care.

Identification. Students must wear identification badges at all times while at the Hospital so that anyone coming in contact with them at the Hospital is able to identify the Student's status.

System Access. Students shall be provisioned access to Hospital IT systems solely for education and

training purposes. Students must agree to the terms in the *Exhibit B EHR Access User and Confidentiality Agreement* prior to accessing Hospital IT systems. Students are required to attend instructor-led one on one training with Clinical Informatics prior to accessing the Electronic Medical Record (Cerner). Students must notify the Medical Staff Office upon program completion. Students that fail to notify the Medical Staff Office of program completion will have their access terminated 30 days after their last day of rotation.

Student access will be processed/completed/terminated by the Medical Staff Office Designee. The Medical Staff Office Designee will:

1. Initiate Student access by submitting a request to onboard the Student in the Human Resource Management System (Workday). Upon approval, Human Resources will onboard the Student's non-employee contract in Workday. Workday will submit a ticket to Identity Access Management to create the Student's active directory account.
2. Obtain secure Student Active Directory logon credentials from IdentityAccessManagement@catholichealth.net. The Medical Staff Office designee will contact Identity Access Management if the Student's Active Directory credentials have not been received in the 120 hours following the Student's contract start date.
3. Request Student Hospital application access via the Total Access Governance Solution (TAGS) and/or Role Based Access Control (RBAC) process. Students will be placed in a position that will allow the system to require at least one co-signature from their Sponsoring Provider on orders.
4. Obtain secure Student Electronic Medical Record (Cerner) logon credentials from IdentityAccessManagement@catholichealth.net. The Medical Staff Office designee will contact Identity Access Management for credentials, if the Student's Electronic Medical Record (Cerner) credentials have not been received in the 72 hours following the TAGS request submission.
5. Share secure Active Directory and Electronic Medical Record (Cerner) Credentials with the Clinical Informatics designees to be provided to the Student at the Electronic Medical Record (Cerner) training.
6. Initiate Student access termination by submitting a request to end the Student's non-employee contract in Workday. Identity Access Management will disable the Student's active directory account immediately following to the non-employee contract end date.

Students shall address issues concerning account matters and password resets by contacting the CHI Help Desk at 866-236-0441 or at CHICustomerSupport@catholichealth.net.

Status. Students are neither employees of the Hospital nor Appointees to the Hospital's Medical Staff. Students are not granted Privileges at the Hospital. Students are not eligible for coverage under the Hospital's workers' compensation programs. The Hospital may temporarily or permanently withdraw one or more Students from the clinical education experience at the Hospital at any time without cause. Notices of such withdrawal shall be sent in writing to the individual's education/training institution, Preceptor(s), and to the Student, as appropriate. Students have no procedural due process rights pursuant to the Medical Staff Bylaws.

CLINICAL ROTATION FOR STUDENTS:

Students may be accepted by the Hospital for a clinical rotation at the Hospital as part of the Student's structured education program through an accredited medical or other appropriate school/university. Students will function in such rotations in accordance with written clinical education/affiliation agreements between the school/university, the Hospital, and all identified Preceptor(s). Prior to the start of the clinical rotation at the Hospital, Students must:

1. Confirm that the Hospital has a current, fully executed written clinical education/affiliation agreement with the school/university and Preceptor(s), as appropriate. A copy of the agreement(s), and any amendments thereto, must be provided to and maintained on file in the Medical Staff Office.
2. Complete/provide documentation as required by the Hospital including, but not limited to, confirmation of the:
    a. Student's status at the educational institution.
    b. Dates of the scheduled rotation at the Hospital.
    c. Name of the Preceptor(s).
    d. Scope of the clinical experience at the Hospital and that the clinical experience is an approved rotation.
    e. Student's professional liability insurance coverage through the educational institution in amounts acceptable to the Hospital.
    f. Student's satisfaction of the Hospital's immunization requirements.
    g. Student's compliance with Hospital requirements regarding criminal background checks.
    h. A copy of Student's current student photo identification card or driver's license for proof of identity.
3. Submit a completed *Statement of Preceptor Responsibility/Agreement* form attached hereto as **Appendix A** as such form may be amended from time to time.

ALL REQUIRED DOCUMENTATION MUST BE ON FILE IN MEDICAL STAFF SERVICES BEFORE THE STUDENT BEGINS A CLINICAL ROTATION AT THE HOSPITAL.

SCOPE OF ACTIVITIES:

Students shall never assume primary care of patients.

Only medical students who have completed Step 1 of the United States Medical Licensing Examination ("USMLE") or the COMLEX-USA level 1 exam are permitted to participate in patient care activities under the direct supervision of a Preceptor. Medical students who have not completed Step 1 of the USMLE or the COMLEX-USA level 1 exam are limited to an observational role while at the Hospital.

Subject to Hospital approval, it is the responsibility of the Student's Preceptor to determine, based upon the Student's education and training, what patient care activities the Student may observe, perform, and/or otherwise participate in at the Hospital.

The scope of allowable patient care activities for Students shall be as set forth in the clinical education/

affiliation agreement between the Hospital and the school/university/Preceptor(s) to the extent such activities are permitted by and provided in accordance with applicable laws, rules, regulations, accreditation standards, and Hospital/Medical Staff policies.

Reviewed:_____ revised:_____
Approved by Board of Directors: September 22, 2020

Approval Signatures

Step Description	Approver	Date
	Dr. Shelley Stanko: Dr.	12/2022
	Tina Turner: Market Director Medical Staff Services	12/2022

CHI Saint Joseph Health

CLINICAL ROTATION STUDENT FORM

Complete if student will be HANDS-ON in the facility

NAME: _____

DOB: _____ EMAIL: _____

HOME ADDRESS: _____

INSTITUTION/TRAINING PROGRAM: _____

YEAR OF TRAINING: _____ CELL PHONE #: _____ NPI #: _____

SS#(REQUIRED FOR BACKGROUND CHECK): _____

***SINGLE ROTATION:** ☐ ***MULTIPLE ROTATIONS:** ☐

DATES OF ROTATION(S)	PRECEPTOR(S)	LOCATION(S)

HAVE YOU COMPLETED A ROTATION AT ANOTHER CHI ST. JOSEPH LOCATION? ☐ YES ☐ NO

*If you answered yes, please indicate which location and when:

_____

MAKE SURE YOU HAVE SIGNED AND EMAILED THE FOLLOWING DOCUMENTS TO THE APPROPRIATE MEDICAL STAFF COORDINATOR:

☐ SUBMIT COPY OF PHOTO

☐ SUBMIT COPY OF IMMUNIZATIONS

☐ SUBMIT COPY OF DRIVER LICENSE

☐ SUBMIT COPY OF INSURANCE

☐ SUBMIT LETTER OF GOOD STANDING

☐ SIGNED CISIVE BACKGROUND RELEASE FORM

☐ SIGNED CONFIDENTIALITY AGREEMENT

☐ SIGNED EXHIBIT B - EHR ACCESS USER AGREEMENT

☐ SIGNED APPENDIX A - EDUCATIONAL OPPORTUNITIES

☐ SIGNED STATEMENT OF AGREEMENT

Revised: 06/2023

☐ SUBMIT PRECEPTOR INDICATION OF STUDENT ACCESS FORM

☐ REVIEW VISITORS IN THE OR POLICY & POLICY REGARDING EDUCATIONAL OPPORTUNITIES

STUDENT SIGNATURE	DATE
SUPERVISING PRECEPTOR SIGNATURE	DATE

Revised: 06/2023

CHI Saint Joseph Health

Confidentiality Agreement

Catholic Health Initiatives, its affiliates and subsidiaries (CHI), treat information about CHI's business and about individuals such as the patient or resident and their families, employees as confidential and take precautions to protect the privacy, confidentiality, and security of this information.

CHI confidential information means any information regardless of the format that it is in (for example, paper, electronic, oral conversations, films) about a patient, resident, employee, student, physician, professional staff, or CHI business and financial operations that is not available to the public. Confidential information includes, but is not limited to, protected health information, billing, payroll, employment records, employee benefits, trademark, copyright, intellectual property, technical ideas and inventions, written published works, contracts, supplier lists and prices, price schedules, business practices, marketing, or strategy, confidential information of third parties for business purposes, or information that is only intended for internal use.

During the course of your employment or association with CHI, you may have access to CHI confidential information. In order to access confidential information you must read the following statements and conditions and indicate your intent to comply.

1. I will look at and use only the confidential information I need to perform my job duties such as to provide health care for a patient, resident or other individuals, or to perform CHI business related job duties.

2. I will not look at confidential information that I do not need to perform my job for my own personal benefit or profit, for the personal benefit or profit of others, or to satisfy personal curiosity, or to disclose or divulge confidential information to others.

3. I will not share confidential information with anyone who is not authorized by CHI to have access to it. If my responsibilities include disclosing confidential information with outside parties such as healthcare providers, contractors, consultants, or insurance companies, I will follow CHI policies and procedures for these types of disclosures.

4. I will take reasonable precautions and follow CHI policies and procedures for safeguarding confidential information to prevent the unauthorized use or disclosure of confidential information.

5. I will ensure that confidential information that I no longer need will be returned and maintained in the appropriate CHI department or location, or in accordance with CHI policies and procedures.

6. I understand that passwords, verification codes, or electronic signature codes assigned to me are the equivalent to my personal signature; and

    - I will only use my password, verification or electronic signature code, in accordance with CHI policies and procedures;

    - I will not use the password, verification or electronic signature code of other CHI employees or individuals authorized by CHI to have such password, verification or electronic signature code;

    - I am responsible and accountable for all entries made and retrievals accessed using my password, verification or electronic signature code regardless of whether it is used by me or by another individual; and

    - I will not use my password, verification or electronic signature code after my employment or affiliation with CHI ends.

7. I understand that CHI issues user identification and secure passwords to access confidential information that is maintained electronically and that CHI periodically monitors access and use of confidential information to determine my compliance with CHI policies and procedures and the terms of this Agreement.

8. If I become aware that another individual has access to or is using my password, verification or electronic signature code or is using his or another individual's password, electronic signature or verification code improperly, I will immediately notify my direct supervisor or the CHI Privacy Officer.

9. I understand and agree to abide by the obligations of this Confidentiality Agreement and associated CHI policies and procedures related to privacy, information security, information technology and confidentiality. I understand that CHI may take disciplinary action if I do not abide by this Confidentiality Agreement and the CHI policies and procedures, including termination of my employment, contract, or association with CHI.

10. I understand that my obligation to maintain the confidentiality of CHI's confidential information extends beyond termination of my employment or association with CHI, and I agree that I will not disclose or use CHI confidential information for any purpose after my employment or association ends**.**

11. I understand that CHI is entitled to take legal action against me if I do not follow this Confidentiality Agreement and CHI's confidential information is used or disclosed inappropriately, including obtaining money damages.

12. I understand that agreeing to comply with CHI policies and procedures to protect confidential information is not an employment contract. I understand that these policies and procedures may be revised or amended at any time and I will be made aware of the updated policies and procedures.

Acceptable Use of CHI IT Assets Agreement

During the course of your employment with Catholic Health Initiatives, or its affiliates and subsidiaries (CHI) you may need to have access to information systems, applications, and information technology network infrastructure (CHI IT Assets) to obtain and use CHI information for your job duties. In order to obtain and maintain access privileges to CHI IT Assets you must read the following statements and conditions and indicate your intent to comply with CHI policies and procedures and this Acceptable Use Agreement.

1. I have read the CHI Acceptable Use Policy. If I have any questions about my use of CHI IT Assets I am to ask my immediate supervisor and/or the ITS Help Desk for assistance. I may access the Acceptable Use Policy by going to Inside CHI or clicking on CHI IT Security Policies and Standards.

2. I understand that CHI maintains ownership of CHI IT Assets and the CHI Information contained on these IT Assets. CHI Information includes information that I may create, access, or obtain on behalf of CHI.

3. I understand that CHI will monitor my access, use, and transmission of information on CHI IT Assets. I do not have, and should not expect any personal privacy rights when using CHI IT Assets.

4. I am not permitted to install or remove any software on CHI IT Assets. If I need specific software for specific job duties, I will obtain approval from my immediate supervisor and request services from ITS Help Desk to install or remove such software.

5. I am responsible for complying with software licensing, copyright, and patent requirements, and the laws which protect these rights. I understand that I am not permitted to download, reconfigure, or reverse engineer any software that CHI uses with its IT Assets.

6. I am responsible for handling CHI Information to prevent unauthorized use or disclosure of CHI Information, and unauthorized access, and use of CHI IT Assets. This includes, but is not limited to taking additional physical precautions to protect IT Assets such as logging out and turning off my computer when not in use, physical protection of IT Assets to prevent theft or loss, such as with mobile devices and laptops, protecting my password from other individuals who may use it inappropriately, and regularly changing my password and making the password complex and difficult to break. I will follow the password requirements set forth in the CHI IT Security Acceptable Use Policy.

7. I am responsible for securing CHI Information when used and disclosed electronically, such as using encryption when sending Confidential Information.

8. I am responsible for knowing and following the acceptable uses of Internet, email, Instant Messaging, file transfer, and proper data storage as set forth in the CHI Acceptable Use policy.

9. I am responsible for protecting CHI IT Assets, including my company computer, from viruses and the introduction of malware. If I have any questions or concerns about unknown emails or internet web sites, I will contact the ITS Help Desk for assistance.

10. I will report all security incidents to the ITS Help Desk regardless of how insignificant I may think the incidents are.

11. I understand and agree to abide by the obligations of this Acceptable Use of CHI IT Assets Agreement and associated CHI policies and procedures while using CHI IT Assets. I understand that CHI may take disciplinary action if I do not abide by this agreement and the CHI policies and procedures, including up to termination of my employment, contract, or association with CHI.

12. I understand that agreeing to comply with CHI Acceptable Use Policy and related policies and procedures is not an employment contract. I understand that these policies and procedures may be revised or amended at any time and I will be made aware of the updated policies and procedures.

I understand that I may access a copy of the **Privacy and Security Standards** by going to the Inside CHI Web site or through these links:

Privacy Standards: http://collab.catholichealth.net/gm/folder-1.11.142497

Security Standards:
http://home.catholichealth.net/portal/site/chihome/menuitem.9330395afff7999de89df0ef43abafa0/?vgnextoid=742b43e4a0610210VgnVCM10000093bcfa0aRCRD&vgnextfmt=default

By my signature below I am indicating that I have read, understand, and agree to adhere to the conditions of this Confidentiality Agreement for continued employment or affiliation with **Catholic Health Initiatives.**

Name (print): _____ ID Number (optional): _____

Signature: _____ Position: _____

EXHIBIT B

ELECTRONIC HEALTH RECORD
ACCESS USER AND CONFIDENTIALITY AGREEMENT
WITH [_____] ("HOSPITAL")

This Agreement must be completed and signed by each individual requesting access to Hospital Electronic Health Records. The Agreement must be completed and returned to the Hospital Information Technology Department before access will be granted.

Organization Name and Address: _____

_____

Site Administrator (Please print): _____

Name of individual requesting access (please print): _____

Job Title: _____

Any previous names used: _____

Direct Work Phone*(required): _____

Home or Mobile Phone*(required): _____

Home Address (cannot be organizational address)*(required): _____

_____

(Cannot be clinic address, home address is required to allow access to medical records.)

Are you a Provider? ☐ Yes ☐ No

Degree: _____

Specialty: _____

NPI: _____

User Attestations

As a user, I attest I:

1. Am an employee or contractor of the healthcare organization named above.
2. Am aware of and agree to comply with state and federal Privacy and Security Rules, including HIPAA.
3. Understand that the use of this IT asset, including associated files or records is strictly limited to activities directly related and appropriate to my job responsibilities.
4. Understand that the use of my identification (ID) and password by anyone other than me is prohibited. If I suspect my account may be compromised, I will report it immediately to (HOSPITAL) by calling 1-866-236-0441.
5. Acknowledge that I will only access patient health information (PHI) of patients who are being treated by the above-named organization for legitimate treatment purposes, payment activities, and/or bona fide healthcare operations.

6. Understand that I have no right or expectation of privacy in my use of this IT Asset. I further consent to HOSPITAL monitoring my use of this system.
7. Will notify HOSPITAL immediately at 1-866-236-0441 of any actual or potential breach of confidentiality or data loss associated with this access.
8. User agrees that any access to Hospital's internal network or other Information Technology assets is subject to CommonSpirit's Data Asset Usage Policy (IT A-002) governing acceptable use of its IT resources, available upon request.

I understand:

- (Insert Facility) is in no way responsible for my or my organization's compliance with HIPAA or any other applicable state or federal regulations.
- Failure to comply with federal or state regulations, including HIPAA privacy and/or security rules, will result in immediate loss of access for me and potentially for my organization. Additional sanctions may be assessed based on severity of violations with federal or state regulations.

_____ _____
User Signature Date

_____ _____
Witness Signature Date

APPENDIX A

STUDENT CLINICAL ROTATION
STATEMENT OF PRECEPTOR RESPONSIBILITY

I hereby declare that _____ (Student) who is enrolled at _____ will participate in a clinical experience at _____ Hospital ("Hospital"). The Student's clinical experience will begin on the ___ day of _____, 20___ and shall end on the ___ day of _____, 20____.

****

_____ Date: _____

(Signature of Supervising Preceptor)

_____

(Name of Supervising Preceptor – Please Type or Print Legibly)

****

Statement of Agreement

Student and Preceptor

Student Obligations:

I acknowledge and agree that at all times during my clinical rotation at the Hospital I will be under the direct supervision and direction of the St. Joseph Hospital, Saint Joseph East or Saint Berea (Hospital) authorized Medical Staff Appointee(s) and/or APC(s) with Privileges at the Hospital who has agreed to be my Preceptor (Preceptor). I will abide by and comply with all directives given to me by such Preceptor(s) during my clinical rotation at the Hospital.

I have read and agree to comply with all applicable Hospital and Medical Staff policies during my clinical rotation at the Hospital. Such policies were made available to me as part of my clinical rotation orientation.

I understand that I am to consider all information regarding patients as privileged and confidential information in accordance with applicable laws, rules, and regulations, and applicable Hospital/Medical Staff policies. I commit to protecting the privacy of Hospital patients and I will not divulge, release, or share information that is confidential with any other individuals or entities except as permitted or required by applicable laws, rules, and/or regulations, and in accordance with applicable Hospital/Medical Staff policies.

I understand that I must wear a photo identification badge that identifies me as a Student while on Hospital premises.

I attest to the following health status requirements and have provided evidence of the following to the Hospital, as applicable, consistent with current requirements:

- Negative tuberculin skin test or negative chest x-ray within past year.
- An immunization record of MMR indicating positive history or titer.
- Proof of Hepatitis B vaccine, or documentation of initiation of Hepatitis B vaccine, or a declination/waiver form signed by me.
- Proof of current flu vaccine – during flu season
- Such other immunizations/vaccines as required by applicable Hospital policies.

I have provided Hospital with evidence of my professional liability insurance coverage consistent with applicable requirements, as applicable, consistent with current requirements.

I have provided the Hospital with the information necessary to complete a criminal background check on me.

I have provided the Hospital with a copy of my current student photo identification card or driver's license for proof of identity.

I have completed or obtained and submitted such other documentation as requested by the Hospital in connection with my clinical rotation at the Hospital. I will promptly notify Hospital of any changes to the information completed or provided during my clinical rotation at Hospital.

I acknowledge that my participation in the clinical rotation at the Hospital may be terminated by the Hospital with or without cause at any time.

Preceptor Obligations:

I understand the expectations regarding the proposed clinical rotation at the Hospital.

I agree to supervise my assigned Student in accordance with applicable laws, rules, regulations, accreditation standards, and Medical Staff and Hospital policies and to be responsible for the Student at all times that the Student is on Hospital premises.

I have read, understand, and agree to comply with the Medical Staff Policy Regarding Educational Opportunities and, as applicable, the CMS *Guidelines for Teaching Physicians, Interns, and Residents*.

I understand and agree to be responsible for apprising the Student of the requirements that the Student must comply with while present on Hospital premises.

The Student will perform all activities under my direct supervision and I will assume full responsibility for the actions of the Student including obtaining consent from the patient prior to the Student's observation of, or participation in, patient care activities at the Hospital.

Student Signature:_____Date:_____.

Student Name (printed) _____

Preceptor Signature: _____ Date:_____

Preceptor Name (printed) _____

CHI Saint Joseph Health

STUDENT CLINICAL ROTATION
PRECEPTOR INDICATION OF STUDENT ACCESS FORM

Complete if student will be HANDS-ON in the facility

The student's clinical rotation training plan is established by the preceptor. It's critical that the preceptor clarify whether the student's rotation will require access to an EHR. Before accessing the system, students must complete training if they need access to the EHR system.

Please identify what type of EHR access the student will need during rotation by selecting ONE checkbox below.

Student Name: _____

TYPE OF ACCESS	CHOOSE ONLY ONE
NO ACCESS NEEDED	☐
VIEW ONLY	☐
DOCUMENT AS A STUDENT	☐

_____
Preceptor (Print Name)

_____ _____
Preceptor Signature Date

Revised: 12/2023

CommonSpirit

INVESTIGATIVE CONSUMER REPORT DISCLOSURE

In connection with your application for Medical Staff membership and privileges in addition to your ongoing Medical Staff membership and privileges with CommonSpirit Health (the "Company"), we may obtain "investigative consumer report(s)" that include information as to your character, general reputation, personal characteristics, and mode of living, whichever are applicable.

If the Company obtains an investigative consumer report, you have the right to request disclosure of the nature and scope of the report which may involve personal interviews with sources such as your neighbors, friends, or associates. Upon your written request to the Company, you are entitled to receive additional disclosures regarding the nature and scope of the investigation and a summary of your rights under the Fair Credit Reporting Act (FCRA). You may also obtain a summary of your rights under the FCRA at *https://files.consumerfinance.gov/f/documents/bcfp_consumer-rights-summary_2018-09.docx*.

AUTHORIZATION TO OBTAIN CONSUMER REPORTS

I hereby authorize CommonSpirit Health (the "Company"), now or at any time while I am in a relationship with the Company, to obtain an investigative consumer report(s), about me.
This authorization does not authorize the release of medical or financial (credit) information.

I represent that the information provided in or attached to this authorization is complete and accurate. I fully understand that a condition of the application process is that any misrepresentation, misstatement or omission from the authorization or application, whether intentional or not, is cause for denial of this application and may result in the denial of appointment and clinical privileges. Upon discovery of such misrepresentation, misstatement or omission, CommonSpirit Health may take immediate corrective action, including, but not limited to, denial of my application or request for privileges and revocation of my appointment and clinical privileges without access to fair hearing processes.

_____ _____

Applicant's Signature Today's Date

_____

Applicant's Name Printed