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Application for Student Rotation at FMG

Student Placement Packet

Check type of Student			
☐ **MEDICAL STUDENT**	☐ **NURSE PRACTITIONER STUDENT**	☐ **PHYSICIAN ASSISTANT STUDENT**	☐ **OTHER:** (i.e. Residency, Fellowship, Observership) _____

Check type of Student Placement			
☐ **CLINICAL ROTATIONS**	☐ **INTERNSHIP**	☐ **JOB SHADOW**	☐ **RESIDENT OR FELLOW**
Last Name:	First Name:	Middle Initial:	Date of Birth:
E-mail Address:		Phone Number:	☐ Male ☐ Female
WA State Medical License # (If applicable):		Expiration date:	University/College:
School / University Coordinator's Name:		School / University Coordinator's E-mail or Phone No.:	

Schedules of Rotations/Other:	**Autumn Quarter** (circle days of rotations) M T W TH F S SU Start Date: ___/___/___ End Date: ___/___/___	**Winter Quarter** (circle days of rotations) M T W TH F S SU Start Date: ___/___/___ End Date: ___/___/___	**Spring Quarter** (circle days of rotations) M T W TH F S SU Start Date: ___/___/___ End Date: ___/___/___	**Summer Quarter** (circle days of rotations) M T W TH F S SU Start Date: ___/___/___ End Date: ___/___/___

BRIEF DESCRIPTION OF STUDENT PARTICIPATION:

REQUIRED DOCUMENTS must be received two (2) weeks prior to the start of your rotation

- Completion of this Student Placement Packet (3 page form)
- CV or an outline of education and experience
- TST Skin Testing information * current within one year (see attached guidelines)
- Current Immunization Record (Hep B, MMR, Varicella, Tetanus/Diphtheria, TST, Influenza)
- Copy of a government issued photograph ID (copy driver's license or passport * SCAN works best)
- Signed "Scope of practice" and "Letter of Agreement" (it is the students' responsible in obtaining the sponsor signature with whom they will be rotating)
- School/university must provide: Student background check, Professional Liability Insurance, and any Completed license(s).
- **IF YOU HAVE BEEN CONVICTED OF A MISDEMEANOR OR FELONY, PLEASE PROVIDE FULL DETAILS OF THE INCIDENT AND CIRCUMSTANCES.**

PLEASE NOTE:

All required documents should be submitted to Fonda Oliver, Credentials Specialist. Please scan or fax documents to:

E-mail Address: FondaOliver@chifranciscan.org or Fax: (253) 426-6939

ANY FURTHER QUESTIONS and/or CONCERNS PLEASE CONTACT Fonda Oliver at (253) 426-4694

Mailing Address:
CHI Franciscan Health
Medical Staff Office
Attn. Fonda Oliver
1708 S Yakima, M-S 03-21
Tacoma WA 98405

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This form must be completed for EACH ROTATION at FMG Clinic(s).

The following are the general guidelines and requirements for bringing a student into a clinic or hospital for the observation of patient or in-hospital patient care activities.

SCOPE OF PRACTICE

- Direct supervision by the sponsor or designee shall be maintained at all times. Direct supervision is defined as physically present.
- Preceptor/Sponsor shall ultimately be responsible for the care of the patient.
- Student may accompany the preceptor/sponsor on all in-house patient care activities, but shall have no direct patient responsibilities. The patient must be informed of the students' status. Only after a patient consents, the student may participate in minor procedures for which the preceptor/sponsor is credentialed and may assist only under the direct supervision of the preceptor/sponsor. A student's participation is expected to be minor, such as changing dressings.
- Student may write progress notes with co-signature by preceptor/sponsor. Progress notes shall be signed, dated and timed by student. Progress notes shall also be signed, dated and timed by the preceptor/sponsor.
- Participate in procedures for which the preceptor/sponsor is credentialed, to scrub, assist with retraction, suctioning, suturing and cutting sutures during operative procedures under the direct supervision of the preceptor/sponsor.
- Job Shadow participation is limited to **observation only** and is at the discretion of the assigned preceptor/sponsor.
- Job Shadow participants are limited to 1-2 days experience only and are not authorized to do any tasks (patient care, or incidentals). Violation of this policy is grounds for immediate dismissal.

LETTER OF AGREEMENT

- Student must be enrolled in good standing at their respective University/College. Physician/Advanced Practice Provider (APP) Sponsor must provide FMG & FHS with evidence of such good standing.
- There shall be an education affiliation agreement between the University/College and Franciscan Medical Group.
- Student is covered by adequate medical malpractice insurance of at least $1,000,000 per occurrence and $3,000,000 aggregate coverage, and covered by adequate health insurance. Student shall provide documentation of adequate medical malpractice insurance coverage.
- Student will participate in a two to four or six to eight week rotation/preceptorship rotation depending on student's curriculum.
- Student agrees to have his/her school or FMG clinic sponsor to do a criminal background check (i.e. WA State Patrol et al).
- The patient must be informed of the students' status. Only after a patient consents, the student may participate in minor procedures for which the sponsor is credentialed and may assist ***only under the direct supervision of the preceptor/sponsor***; participation as outlined above.
- Student must wear a name-badge identifying him/her as a student.
- Student must forward all the required documents to the FMG Quality & Risk Management Department, Attn: Debi Burleson, for review at least two weeks prior to start of their rotation/preceptorship and will be notified when approved.
- Prior to arrival of the student, the preceptor/sponsor will notify the clinic manager and department about the presence of the medical student, the dates when he/she will be at the facility and the type of student placement/program.
- Preceptor/Sponsor must be clearly identified; and must agree to accept full responsibility for direct supervision at all times.
- Preceptor/Sponsor shall introduce the student to the patient and assure appropriate consent is obtained for observation and/or participation.

DATES of clinical rotations/other:	**CLINIC where you will do rotations:**	**Name of your Preceptor / Sponsor:**
FR:_____THRU_____	_____	_____

My signature below indicates that I acknowledge these guidelines/scope of practice and agree to be bound by the requirements as outlined above.

_____ _____
Student Signature Date

_____ _____
PRINT STUDENT NAME **SCHOOL / UNIVERSITY NAME**

****NOTE: MUST BE SIGNED BY PROVIDER WHO IS SPONSORING/PRECEPTING YOU****

My signature below indicates that I acknowledge

- **these guidelines and agree to be bound by the requirements as outlined above**
- **the student "scope of practice" outlined above**
- **In addition, my signature below indicates that I assume sole responsibility and liability for the actions of the student.**

_____ _____
Preceptor/Sponsor Signature Date

_____
PRINT PRECEPTOR / SPONSOR NAME

Noted by:

_____ _____
Clinic Manager Signature Date

_____
PRINT CLINIC MANAGER NAME

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CONFIDENTIALITY AGREEMENT

I understand that Franciscan Medical Group (FMG) considers it the ethical responsibility of each employee, contracted employee, student or volunteer to respect and maintain the confidentiality of patients, physicians and fellow staff members, as well as organizational information. Therefore, it is expected that I will be worthy of the trust given me and that I will perform my duties to the best of my ability with intelligence, courtesy, tact, and cheerfulness.

I acknowledge that access to confidential information is for the purpose of performing my responsibilities within this organization and for no other purpose. I understand that confidential information is protected in every form, such as written records and correspondence, oral communications, and computer programs and applications. Medical records are legal documents and contain confidential information. Staff must use extraordinary caution when handling records. Unauthorized disclosure of medical record information could result in legal action against the hospital and against the employee or volunteer who violates the patient's rights.

I understand that all information regarding patients and their health care is strictly confidential. Information of a privileged nature is to be shared only with authorized parties and such discussions should be held in a private location.

I understand that information of a personal nature regarding fellow co-workers is also considered confidential. Employees' addresses, home phone numbers, work schedules, and any other personal information shall not be released to a third party without the express permission of the employee involved. All requests for employment verification or job references must be referred to the FMG Human Resources Department.

I understand and agree that in the performance of my duties as an employee, contracted employee, student or volunteer Franciscan Medical Group, that I must hold patient, physician, employee and organizational information in confidence. I understand that any violation of the confidentiality policy may result in corrective action, including termination. I agree that my obligations under this agreement continue after my employment ends.

Print Name (including middle initial)	Signature
FMG Clinic / Facility Name	Date(s) in Clinic
Noted by: Preceptor / Sponsor Name	Preceptor / Sponsor Signature

CHI FRANCISCAN HEALTH
Child and Adult Abuse Information Act

In 1987, the Washington State Legislature passed the Child and Adult Abuse Information Act. This law requires that all employees and volunteers hired on or after January 1, 1988 who will or may have unsupervised access to and who will or may be directly responsible for the care, supervision, or treatment of children or developmentally disabled persons, must make a written disclosure of certain civil adjudications, convictions, records of a crime(s) against persons and for licensed personnel, disciplinary board final decisions. Background inquiries on these matters may be made to the Washington State Patrol or to other state or federal law enforcement agencies. If the background inquiry is negative, you will be contacted regarding status of volunteering. If satisfactory, your employment application will be processed as normal. In compliance with this law, we are required to obtain disclosure statements from newly hired employees and volunteers as outlined above. All information obtained will remain confidential. It is a condition of volunteering that this information be provided.

Yes No **Have you ever been convicted of a crime against persons? A crime against persons includes any of the following offenses:** aggravated murder; first or second degree murder; first or second degree kidnapping; first, second or third degree assault; first, second or third degree rape; first, second or third degree statutory rape; first or second degree robbery; first degree arson; first or second degree manslaughter; first degree burglary; first or second degree extortion; indecent liberties; incest; vehicular homicide; first degree promotion prostitution; communication with a minor; unlawful imprisonment; simple assault; sexual exploitation of minors; first or second degree criminal mistreatment; or any of these crimes as they may be renamed in the future.

Yes ____ No __ Have you ever been found, in a disciplinary action, domestic relations proceeding or disciplinary board final decision, to have sexually assaulted or exploited a minor or to have sexually abused a minor?

Yes ____ No __ Have you ever been convicted of (a) crime(s) related to drugs? "Related to drugs" means manufacture, delivery or possession with intent to manufacture or deliver a controlled substance.

Yes ____ No __ Have you ever been found in a dependency action to have sexually assaulted or exploited any minor or been found guilty of child neglect or abuse or to have physically abused any minor.

Yes No Have you been arrested or convicted of any offense in the past seven (7) years?

Yes ____ No __ Have you been released from prison in the past seven (7) years?

If your answer is "Yes" to any of the above questions, please describe and provide the date(s) of the findings(s) and the penalty (penalties) imposed on the back of this paper. Attach additional pages as necessary.

We require your legal name and birth date, plus other information, to obtain from the Washington State Patrol criminal identification system, a report of your record and criminal convictions for offenses against persons, civil adjudications of child abuse and disciplinary board final decisions. A thumbprint may be required to later verify information received from the State Patrol. We will make a copy of the report available to you upon your request.

Applicant's Name: Last_____ First_____ Middle _____

Alias/Maiden Name: _____Date of Birth: ___/___/___ Sex: M ☐ F ☐

Driver's License #:_____State:_____ Expiration Date:_____

Under penalty of perjury, I certify that the above information is true, correct, and complete. I understand that I can be discharged from volunteering for any misrepresentation or omission in the above statement. I also understand that my volunteer status is conditioned on your receipt of a satisfactory report from the Washington State Patrol.

Signature: _____ Date: _____