

OBSTETRICS & GYNECOLOGY

University of Washington Medical Center

Dear Student,

We would like to welcome you to your Obstetrics and Gynecology Basic Clerkship. During this six-week clerkship, you will have the opportunity to apply and increase your knowledge in both clinical and didactic settings. Our faculty members enjoy teaching, especially in a one-on-one basis. We hope you will take advantage of their expertise and learn as much as possible; do not be afraid to ask questions.

First day of the rotation:

Please meet Dr. Eberhardt at 8:00 am at the Women's Clinic.

Two weeks prior to the rotation, contact Dr. Eberhardt for further details:

Email: keberhar@hotmail.com

Office number: (509) 525-5010

Please contact Tammy Fovler for detailed information on student housing at:
(509) 525-3720

You should review anatomy before the orientation, as well as read the web-based Student Course Guide. You will find the Course Guide especially useful because it contains a description of the clerkship, course requirements, and an explanation of the evaluation instruments.

2009–2010 Dates to Remember: *Walla Walla 696*

Complete, up-to-date clerkship and schedule information is available online at:
www.obgyn.uwmedicine.org/clerkship

Date to Remember	Time	Activity	Location
1 st day of Clerkship	8:00 AM	Orientation	Women's Clinic
	Afternoon		Walla Walla Clinic
Last day of Clerkship	7:45 AM	Return site specific paperwork	UWMC (<i>location announced one week prior, by email</i>)
	8:15 AM	Final written exam	
	5:00 PM	Complete Evaluation Clerkship officially ends	

If you have any questions, either before or during the clerkship, please do not hesitate to call us.

Vicki Mendiratta, MD
Clerkship Director
OB/GYN Division of Education
vmendira@u.washington.edu

Jamie Vickerman
Clerkship Coordinator
206-543-3891
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Facility: WALLA WALLA GENERAL HOSPITAL

System-wide Corporate Policy

Standard Policy

Model Policy:

Policy No.

Page

Department:

Category/Section:

Manual:

1 of 3

Medical Staff

Medical Staff

POLICY: STUDENTS NEEDING CLINICAL EXPERIENCE (Physician Assistant, Medical Student, Nurse Practitioner, Nurse-midwife Student)

POLICY SUMMARY/INTENT:

To provide a framework for organizing clinical experiences at Walla Walla General Hospital for selective students needing clinical skills practice; i.e. students enrolled in Physician Assistant and Advanced Registered Nurse Practitioner or Medical Student programs.

AFFECTED DEPARTMENTS/SERVICES:

All departments or services of Walla Walla General Hospital.

POLICY: COMPLIANCE – KEY ELEMENTS

A. Policy

1. A contract between Walla Walla General Hospital and the school will be signed by the Hospital President or his designee. Original contracts will be kept in the Administration Office.
2. Proof of liability insurance held by the school requesting the clinical practicum will be kept on file with the contract.
3. Students are subject to drug testing for cause but will not be screened as a condition of completing their clinical experience.
4. Students, with the assistance of their school, will supply the following documentation prior to starting clinical experiences:
 - a) Letter from the school identifying student and their preceptor (who must be an Active or Courtesy member of the Medical Staff or a licensed independent practitioner on the Allied Health Care Staff in good standing)
 - b) Starting and ending date of clinical experience
 - c) Student CV
 - d) Statement regarding health status
 - e) Evidence of instruction in all applicable state or federal mandated topics affecting healthcare providers, including, but not necessarily limited to, hazardous materials handling and disposal, as well as bloodborne pathogens
 - f) Overview of objectives pertaining to clinical experience/type of experience desired
 - g) Evidence of malpractice insurance
 - h) Student immunization record
 - i) Washington State Patrol Criminal History Background Check
 - j) Completed Confidentiality Statement
 - k) Proof of negative TB (tuberculin or chest X-ray) status within past year
 - l) Proof of Hepatitis B immunity or immunization series started

5. Walla Walla General Hospital maintains the right to remove a student from clinical experience whose performance is detrimental to the well being of any patient or the achievement of the school's or hospital's objectives.
6. Students are required to comply with all policies and procedures of Walla Walla General Hospital during their clinical experiences. Students will review and sign the Agreement of Confidentiality, Attachment A.
7. No student shall have access to, or have the right to review, any medical record or patient information, except where necessary in the regular course of the program. The discussion, transmission or narration in any form by students of any patient information of a personal nature, medical or otherwise, obtained in the regular course of the program is forbidden, except as a necessary part of the program.
8. Walla Walla General Hospital retains full administrative and clinical responsibility for the care of its patients. Students, as participants in this education program, shall not replace staff.

B. Approval Process

1. The Medical Staff Office will obtain the documents identified in section A, 4, and record them on the Student Request Review Form, Attachment B. When this form is complete, the file will be reviewed at Bylaws/Credentials Committee, Executive Committee, and submitted to the hospital's Governing Board for approval.

C. Level of Participation

1. The student is permitted to perform and/or assist with procedures only under the direct supervision of his/her preceptor. **The preceptor will be responsible for the student's actions.**
2. If the student performs a history and physical examination, this must be accompanied by a history and physical examination performed by the preceptor, who will be an Active or Courtesy member of the Medical Staff in good standing.
3. Students may **not** write or give orders.

AGREEMENT OF CONFIDENTIALITY

As an employee, volunteer or student of Walla Walla General Hospital, I understand that this hospital is governed by Federal Regulations on Confidentiality and I agree to treat any information that I come in contact with as confidential. I may not discuss outside of this setting any particular patient I might see or receive information about, except as I am specifically allowed to through signed Release of Information.

This also means that I may not acknowledge that I have seen any individual here as a patient, without specific written consent of that individual.

It is understood by the employee, volunteer or student that any unauthorized disclosure of patient information is a federal criminal offense punishable by a fine of not more than \$500 in case of first offense, and not more than \$5,000 in case of each subsequent offense.

Executed this _____ day of _____, 200__.

Signature of Employee/Volunteer/Student

Authorized Signature

**STUDENT REQUEST REVIEW FORM
WALLA WALLA GENERAL HOSPITAL**

Student Name: _____

Date Rec'd: _____

Dates of Training: From: _____

To: _____

Supervising Physician: _____

Student Type:

- Physician Assistant
 Medical Student
 Nurse Practitioner
 Nurse-midwife Student

The following information must be available in order for this request to be processed:

- School contract on file
 Letter from school identifying student and their preceptor
 Student CV
 Statement regarding health status
 Documentation of completion of program on handling and disposal of hazardous materials and bloodborne pathogens
 Overview of objectives pertaining to clinical experience/type of experience desired
 Evidence of malpractice insurance
 Student immunization record
 Washington State Patrol Criminal History Background Check
 Completed confidentiality statement
 Documentation of negative TB (tuberculin or chest X-ray) status within past year
 Documentation of Hepatitis B immunity or immunization series started

To Bylaws/Credentials Committee: _____

To Executive Committee: _____

To Hospital's Governing Board: _____

STATEMENT REGARDING HEALTH STATUS

AFFIRMATION OF ABILITIES			
1.	Do you presently use any drugs illegally?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2.	Do you have, or have you had in the last two years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. <u>If the answer to this question is yes</u> , please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Signature

Date