UW Medicine
SCHOOL OF MEDICINE

Department of Obstetrics & Gynecology
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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.

Your orientation will take place in Bozeman on the first day of your rotation. Please email Dr. Bradford one week before the start of your rotation to schedule your orientation. tbradford@billingsclinic.org You should review pelvic anatomy before the orientation, as well as read the web-based Student Course Guide. You will find the web-based Course Guide especially useful because it contains a description of the clerkship, course requirements, and an explanation of the evaluation instruments. The Guide also includes the required topics for course reading. It will be to your benefit to be familiar with all the topics listed, either through experience or through reading.

Your rotation schedule will be given to you during orientation at the site. You will need your black bag of instruments for clinic.

Please send the Student Checklist to Selina Irby four weeks prior to your start date.

Selina Irby
Bozeman Deaconess Hospital
915 Highland Blvd.
Bozeman, MT 59715
Phone (406)556-5186
sirby@bdh-boz.com

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

Date to Remember	**Time**	**Activity**	**Location**
1st day of Clerkship	8:00 AM	Orientation	Bozeman Deaconess Hospital 925 Highland Drive, #1210 Bozeman, MT 59715
Last day of Clerkship	8:00 AM	Final written exam Complete Evaluation	Billings or Seattle
	5:00 PM	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

Whitney Hiatt
Clerkship Coordinator
206-543-3892
whiatt11@u.washington.edu

Bozeman Deaconess
HOSPITAL

COMPUTER SECURITY AGREEMENT

This form must be legible and complete. Incomplete forms will be sent back to the supervisor. This will delay access for the employee.

Computerized information systems are an important asset of Bozeman Deaconess Hospital. The privacy of our patients depends on the protection of this information against theft, destruction, or disclosure to outside interests.

Therefore, **I agree to the following provisions:**

- ✓ Not to operate computer equipment or demonstrate the operation of computer equipment without specific authorization.
- ✓ To maintain assigned passwords that allow access to computer systems and equipment in **complete confidence and not disclose a password to anyone, at any time, for any reason.**
- ✓ To only access computer systems, equipment, and functions **as required for the performance of my responsibilities.**
- ✓ To contact information systems personnel immediately and request a new password(s) if mine has been accidentally revealed.
- ✓ Not to disclose any portion of a patient's record except to a recipient or medical practice designated by the patient or to a recipient authorized by BDHS who has a need-to-know in order to provide for the continuing care of the patient.
- ✓ To refrain from making any changes of any type to the personal computer(s) supplied by the hospital in cases where a PC is supplied.
- ✓ To report any activity contrary to this agreement to BDHS Information System's personnel.
- ✓ I understand that failure to comply with the above policies may result in formal disciplinary action, up to and possibly including termination or cancellation of agreements.

If personal computer access is given, United States copyright laws relating to software must be strictly obeyed. **Therefore I agree to ALWAYS:**

- ✓ Purchase software through BDHS Information Systems;
- ✓ Deliver software to Information Systems upon arrival for inventory and registration;
- ✓ Never download or install software or shareware from any source without Information Systems approval;
- ✓ Never copy software to other computers;
- ✓ Never take software home for personal use and always delete the old versions of software when an upgrade is installed.

Signature: _____ **Date:** _____

Printed Name:_____

Bozeman Deaconess
HOSPITAL

BDHS SECURITY AGREEMENT CONTINUED

COMPLETE ALL FIELDS

CIRCLE the Employee type: Regular Temporary Agency Volunteer Vendor

Last Name_____ First Name_____ MI:____

Phone#_____ Position Title:_____

Name of Dept or Group_____

Reason for Action:

- ☐ **New Employee**
- ☐ **Change of Position – Prior Title _____**
- ☐ **Menu Change: _____**
- ☐ **Other: _____**

Date Access should begin_____

For Changes of Position, enter the date prior access rights should end _____

This person should be set up the same as:_____

(***Name of existing staff member that this person's setup should emulate)***

NO ONE SHOULD BE AUTHORIZED TO USE PCI (Patient Care Inquiry Module) AT ANY LEVEL BEYOND WHAT IS ABSOLUTELY NECESSARY TO PERFORM JOB FUNCTION!

Is Patient Care Inquiry access necessary? Yes_____ No_____
If Yes, Restricted to Non-confidential patients? Yes _____ No _____

Please check the required system(s) access:

Meditech ____ MSM MedSurg _____ ImageNow _____ NextGen EPM**_____ NextGen EMR**_____
Outlook E-mail _____ Docuware _____ Windows _____ Amicas PACS _____

*(*Kronos requires sign-off from the Finance Dept) (**For NextGen please complete supplement form)*

Supervisor Signature:_____ Date:_____

Supervisor Phone: _____

Finance Approval for KRONOS: _____ Date: _____

Information Systems Use Only

Sign Off:: Eric_____ Julie _____ Chris _____ MiChelle_____ Shannon _____
Mark _____ Kim_____ Dan_____ NextGen Analyst_____

Final Sign-off date: _____

Meditech Mnemonic: _____

Name of Student_____

Name of Doctor/Group _____

Dates of Rotation _____

Student Rotation Credentialing Checklist

The following information must be provided to Bozeman Deaconess Administration for students who are requesting rotations with Medical Staff members prior to beginning their rotation.

*NOTE: **The supervising Medical Staff member must be present with the student during their rotation.***

Student Rotation Credentialing Checklist

The following information must be provided to Bozeman Deaconess Administration for students who are requesting rotations with Medical Staff members prior to beginning their rotation.

*NOTE: **The supervising Medical Staff member must be present with the student during their rotation.***

____Student's Photo (copy of Drivers license or Passport will work)

___ CV

___ Immunization Record.

___ Copy of Confidentiality Agreement

___ Copy of Computer Security Agreement

___ Copy of the Agreement between the Medical Staff member and the school indicating dates of rotation.

___ Letter of good standing with the school.

___ Copy of Affiliation agreement with BDH

___ Documentation that the student is covered by the school's professional liability insurance including dates and amounts of coverage.

___ Letter from Medical Staff member indication they will be supervising the student during the specific dates (and who from their group would be supervising in the physician's absence).

___ Proof of surgical rotation, if completed or documentation of training in sterile technique and scrubbing for surgery. *The Visitor is required to contact the Surgical Services Educator (522-1689) within a timely period prior to the visit.* (Not applicable if not going into O.R.)

_____ _____

Signature Admin **Date**

Bozeman Deaconess
HOSPITAL

CONFIDENTIALITY COMMITMENT

As a Bozeman Deaconess Hospital (BDH) employee, volunteer, committee member, or visitor, I recognize that assuring confidentiality is an ethical, moral and legal responsibility. Patients, employees, and business associates of BDH have the right to expect that confidential information of all kinds—medical, personnel, business and financial (verbal, written or computerized)—will be safeguarded. Such information may be accessed, used, and discussed only by those with an authorized need to know, and may not be released or disclosed, except in accordance with BDH policies and agreements.

I recognize that due to the nature of my involvement with BDH, I agree to be obligated to follow BDH policies that protect confidentiality. These policies protect the confidentiality of patient health care information and of strategic business and financial information. Furthermore, I understand that these policies may be amended and new policies may be issued that protect the confidentiality of information, and I agree to follow such new policies as they are issued. Furthermore, I understand that, under special circumstances, BDH will enter agreements to share confidential business, financial or patient-related information with outside persons or organizations, with the obligation to hold such information in confidence. I agree to abide by such agreements.

I understand that failure to protect the confidentiality of information may be grounds for civil penalties under the Montana Health Information Act or the Health Insurance Portability and Accountability Act (HIPAA) and violation of BDH policies and agreements that protect the confidentiality of information will result in disciplinary action, which may include termination.

If I have a question or concern about BDH policies and expectations regarding confidentiality, I will ask my supervisor, department manager, a member of senior leadership, or the Compliance Officer. If I know of a breach or possible breach of confidentiality, I also recognize that I am obligated to report that breach to my supervisor, department manager, or the Compliance Officer.

_____ _____ _____

Signature Department/Position Date

_____

Print Name Here

Bozeman Deaconess Hospital Employee Health
Immunization History
Tel: 406.556.5566 Fax: 406.556.5561

Name:		**Birth Date:**	**Social Security#**
Dept:	❑ **New Employee**	❑ **Volunteer**	❑ **Student**
Emergency Contact:		**Emergency Contact Phone Number:**	

Please complete the immunization history to the best of your knowledge. If you know that you have had the vaccine, but do not remember when, mark yes and indicate the approximate date. If you have not received the Hepatitis B series please contact Employee Health. Due to the fact that you work in an area where you could be exposed to potentially infectious materials, it is your right to receive the Hepatitis B series at no cost to you. Attach any immunization and or TB records to this record.

Vaccine	History	Date of Immunization
Hepatitis B	❑ I have not received the Hepatitis B vaccination series See consent and declination below ❑ I have received the Hepatits B vaccination series ❑ I have proof of vaccination or positive titer (please submit) Titer Results_____	#1 _____ #2 _____ #3 _____
Varicella Or Chicken Pox	❑ I have not had Varicella (Chicken Pox) ❑ I do not know if I have had Varicella (Chicken Pox) ❑ I have had Varicella (Chicken Pox) ❑ I have proof of Vaccination or positive titer (please submit)	Year _____ Date _____
Hepatitis A	❑ I have not received the Hepatitis A vaccination series ❑ I have received the Hepatitis A vaccination series	#1 _____ #2 _____
MMR	❑ I have not received the MMR vaccination series ❑ I have received the MMR vaccination series	Year _____ Year _____
Tetanus Diphtheria Pertussis		Date _____ Date _____
Other	❑ _____ ❑ _____	Date _____ Date _____

Hepatitis B Consent/Declination

❑ **I Decline:** My signature below acknowledges that I have been given the opportunity to be vaccinated for hepatitis B, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future if I want to be vaccinated with hepatitis B vaccine and I am still employed with BDH, I can receive the vaccination series at no charge to me.

❑ **I Consent:** As a healthcare professional having exposure to blood or other potentially infectious materials, which includes the risk of acquiring Hepatitis B virus (HBV) infection, I have been informed about and offered the opportunity to receive the Hepatitis B vaccine (to be paid for by my Bozeman Deaconess Hospital). I understand that I must have 3 doses of vaccine to develop immunity. However, as with any medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effect from the vaccine. I accept the offer at this time.

_____ _____
Employee Signature **Date**

Bozeman Deaconess Hospital Employee Health
Latex Questionnaire
Tel: 406.556.5566 Fax: 406.556.5561

Name:	Dept:	Date:

Have you ever suffered from the following?	**Yes**	**No**	**If Yes, Please Explain**
Allergic Rhinitis (Runny Nose)	☐	☐	_____
Allergic Conjunctivitis (red, swollen, watery eyes)	☐	☐	_____
Asthma	☐	☐	_____
Bronchitis (difficulty breathing)	☐	☐	_____
Eczema	☐	☐	_____
Hay Fever	☐	☐	_____
Hives	☐	☐	_____
Sinus Problems	☐	☐	_____
Unexplained Rash	☐	☐	_____
Reaction to Band-Aids/Tapes	☐	☐	_____
Have you ever reacted after handling/using?	**Yes**	**No**	**If Yes, Please Explain**
Poinsettia Plant	☐	☐	_____
Balloons, Condoms	☐	☐	_____
Rubber Products	☐	☐	_____
Clothing with Elastic or Spandex	☐	☐	_____
Elastic Bandages	☐	☐	_____
Have you ever had any of the following symptoms after a dental appointment, pelvic or rectal exam?	**Yes**	**No**	**If Yes, Please Explain**
Itching	☐	☐	_____
Tearing	☐	☐	_____
Fatigue	☐	☐	_____
Sneezing	☐	☐	_____
Runny Nose	☐	☐	_____
Have you ever reacted after eating?	**Yes**	**No**	**If Yes, Please Explain**
Avocados	☐	☐	_____
Bananas	☐	☐	_____
Tropical fruit such as Kiwi, Passion Fruit, Pineapple	☐	☐	_____
Chestnuts	☐	☐	_____

Comments or concerns: _____

_____

_____

_____

Bozeman Deaconess
HOSPITAL

COMPUTER SECURITY AGREEMENT FOR PROVIDERS

Date Access should begin_____ **Name of Medical Group**_____

Last Name_____ **First Name**_____ **MI:**____ **Phone#**_____

☐ **New Employee**

☐ **Change of Position – Prior Title:**_____

☐ **Menu Change:** _____

☐ **Other:** _____

REQUIRED! This person should be set up the same as:_____
(Name of existing staff member that this person's setup should emulate)

NO ONE SHOULD BE AUTHORIZED TO USE PCI (Patient Care Inquiry Module) AT ANY LEVEL ABOVE AND BEYOND WHAT IS ABSOLUTELY NECESSARY TO PERFORM JOB FUNCTIONS!

Is PCI access necessary? Yes_____ No_____ If so, at what level of security?
Restricted to Non-confidential patients only?_____
Restricted to assigned provider's patients only?_____

MSM ☐ PACS ☐ MEDITECH ☐ NEXTGEN ☐ INTERNET ☐ OTHER ☐

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- ✓ To maintain assigned passwords that allows access to computer systems and equipment in **complete confidence and not disclose a password to anyone, at any time, for any reason.**
- ✓ To only access computer systems, equipment, and functions **as required for the performance of my responsibilities.**
- ✓ To contact information systems personnel immediately and request a new password(s) if mine has been accidentally revealed.
- ✓ Not to disclose any portion of a patient's record except to a recipient or medical practice designated by the patient or to a recipient authorized by BDHS who has a need-to-know in order to provide for the continuing care of the patient.
- ✓ To refrain from making any changes of any type to the personal computer(s) supplied by the hospital in cases where a PC is supplied.
- ✓ To report any activity contrary to this agreement to BDHS Information Systems personnel.
- ✓ I understand if my PC is connected to the BDHS network that confidential information on my PC may be susceptible to exposure unless precautions are taken on the part of my office to set up a firewall.
- ✓ I understand that failure to comply with the above policies may result in formal disciplinary action, up to and possibly including termination or cancellation of agreements.

Computer Access User Signature: _____ **Date:**_____

Computer Access User Printed Name: _____

Practice Manager Signature: _____

Information Systems Use Only

Sign Off Julie _____ Kim _____ MiChelle_____ Eric _____
Shawna_____ Danny _____Chris_____ Dustin_____

Meditech Mnemonic: _____

Revised July 2011

Bozeman Deaconess Hospital Employee Health
Tuberculin Skin Test

Tel: 406.556.5566 Fax: 406.556.5561

Name:		Birth Date:	Social Security#
Dept:	❑ New Employee	❑ Volunteer	❑ Student

All employees and volunteers are enrolled in the Tuberculosis Surveillance Program. This means that <u>all</u> new employees and volunteers will need to have a 2-step skin test unless they have documentation of negative TB test in the past year. If so, please bring this documentation to Employee Health.

A Bozeman Deaconess Hospital clinician must read the test 48 to 72 hours after it is placed. You may walk-in between 8am and 4pm or you may call ahead at 556-5565. Evening and Night employees may go directly to the Emergency Department to have their tests placed and read. Please return a copy of the results to Employee Health.

❑ 1st PPD Skin Test

Date Administered	Administered by	Manufacturer: Parkdale PPD 5 TU 0.1 ml ID	
Lot #	Expiration date	Site: ❑ L Forearm	❑ R Forearm
Date Read	Induration	Read by	

❑ **2nd PPD Skin Test**

Date Administered	Administered by	Manufacturer: Parkdale PPD 5 TU 0.1 ml ID	
Lot #	Expiration date	Site: ❑ L Forearm	❑ R Forearm
Date Read	Induration	Read by	