St. Peter's Hospital

APPLICATION TO PROVIDE PATIENT CARE SERVICES

This space for MSS use only

Date Received: _____

INTERIM (STUDENT) PRIVILEGES / SCOPE OF PRACTICE

All information should be legible. If more space is needed, please attach additional sheets and make reference to the question number being answered.

Date of Application:_____

Requested Dates of Rotation: _____ Student: DO MD NP PA (circle one)

Physician(s) Responsible for you during Rotation:_____

1. PERSONAL IDENTIFICATION DATA

1.1 General Information

Last Name:_____ First Name:_____

Middle Name:_____ Personal & Professional Suffixes:_____

Aliases Used:_____

Birth date:_____ Birth place:_____

Social Security Number:_____ Citizenship:_____

Visa Number (if not a citizen of the United States):_____

Visa Status and Expiration:_____

Driver's License Number and State:_____

1.2 Personal Contact Information

Cellular Phone:_____

Home Address:_____

City:_____ State:_____ ZIP:_____

Home Telephone:_____ Home Fax:_____

E-mail (suitible for contact from SPH Medical Staff Services):_____

2. EDUCATIONAL DATA

2.1 Current School or Post Graduate Training Program

College /University:_____ Degree/Certification being Sought:_____

Expected Date of Graduation/Certification:_____

2.2 Other Pertinent Training / Education

1. Program/Institution:_____ Dates:_____

2. Program/Institution:_____ Dates:_____

3. Program/Institution:_____ Dates:_____

3. LICENSURE AND CERTIFICATION DATA

3.1 Licenses

Please complete as applicable.

1. **Montana:**_____ Type:_____
   Number:_____ Original date of issue:_____
   Status:_____ Expiration date:_____

2. State:_____ Type:_____
   Number:_____ Original date of issue:_____
   Status:_____ Expiration date:_____

3. **DEA**:_____ Type:_____
   Number:_____ Original date of issue:_____
   Status:_____ Expiration date:_____

3.2 Certifications

Please complete as applicable.

1. Institution/Orgainzation:_____ Type:_____
   Number/Registration (if any):_____ Original date of issue:_____
   Status:_____ Expiration date:_____

2. Institution/Orgainzation:_____ Type:_____
   Number/Registration (if any):_____ Original date of issue:_____
   Status:_____ Expiration date:_____

3. Institution/Orgainzation:_____ Type:_____
   Number/Registration (if any):_____ Original date of issue:_____
   Status:_____ Expiration date:_____

4. ADDITIONAL QUESTIONS AND REQUIRMENTS

4.1 Additonal Questions

- Are you currently employed by St. Peter's Hospital? o Yes o No
- Has your sponsoring provider indicated you will be using the dication system? o Yes o No
- Has your sponsoring provider indicated you will need Electronic Medical Record (EMR) access? o Yes o No

(Additional Paperwork Necessary)

4.2 Requirements

The following should be submitted to Medical Staff Services with your application:

1) a letter from the student's school or post graduate training program certifying enrollment and approving the training rotation;
2) evidence of a college/university student affiliation agreement with St. Peter's Hospital (these agreements will be verified by the St. Peter's HR or Education Department);
3) evidence of a criminal background check within the last year;
4) evidence of current workers compensation coverage and liability insurance;
5) a signed confidentiality statement;
6) evidence of a formal arrangement/preceptorship or employment with a provider on the Active Medical Staff or Allied Health Professional Staff (sponsoring provider) of St. Peter's Hospital including a letter from the sponsoring provider accepting responsibility for the student's actions (such letter should outline the beginning and end dates of the student's rotation, where the student will rotate and the expected scope of practice/privileges);
    a) if the sponsoring provider is an allied health professional, evidence of written approval from the appropriate department chair or the President of SPMG (if the student's rotation will be solely with SPMG);
7) evidence of at least temporary medical licensure in the State of Montana for MDs and DOs; and
8) evidence of health screening (Please provide evidence of a PPD test within the last 12 months, date of chicken pox or vaccination record and if born after 12/31/1956 proof of a MMR vacination).
9) Copy of a government issued photo ID as well as a photo suitable for publication.

Once a complete application is received, an orientation will be scheduled with the HR Department. Evidence the applicant has completed an orientation with the HR department must be on file with Medical Staff Services.

5. AFFIRMATION

Please read and certify each of the following to be true by placing a checkmark or a "x" in front of them (in the box provided).

☐ I certify I am mentally, emotionally and physically capable of carrying out my responsibilites as a caregiver.

☐ I certify I have medical malpractice insurance coverage via my school in the amount of $1,000,000-Occurrence/$3,000,000-Aggregate.

Name: (please print clearly)_____

Signature:_____ Date:_____

St. Peter's Hospital

CONFIDENTIALITY AGREEMENT FOR MEDICAL STUDENTS OBSERVING A MEMBER OF THE ST. PETER'S (SPH) ACTIVE MEDICAL STAFF OR A SPH ALLIED HEALTH PROFESSIONAL

I recognize that in observing _____ (provider name), I will have access to very sensitive and confidential information regarding patients, physicians, and staff members.

I understand the vital importance of maintaining all such information and any and all discussions and deliberations regarding the same, in strict confidence. I therefore agree to make no disclosures of this confidential information.

I understand that my breach of this agreement may not only compromise my own interests, but also the interests of St. Peter's Hospital and its Medical Staff. Therefore, in the event of such a breach, I understand that my actions may result in:

(1) immediate removal from SPH premises;

(2) disciplinary action as deemed appropriate by the Executive Committee pursuant to the hospital's Credentialing Policy; and/or

(3) other appropriate legal action.

Name: (please print clearly)_____

Signature:_____ Date:_____

STUDENT PRECEPTOR PRIVACY AND CONFIDENTIALITY AGREEMENT

I am aware that, while on rotation I may be allowed access to private and confidential information through access to St. Peter's Hospital computer data base. This information includes patient protected healthcare information, physician information, financial information and anything learned as a result of working in a student capacity. This information will only be used or disclosed with discretion as necessary to complete my rotation obligations. Patients and their families, the medical staff, administrative staff and employees of St. Peter's Hospital trust that each individual who is given access to this information will comply with this standard of professional conduct.

If there is an unauthorized use or disclosure of confidential information by me, disciplinary action may be imposed, which may include termination of the rotation agreement and removal of my access to the SPH computer data base. I have been provided privacy policies and appropriate training. Any privacy or security violation will result in efforts to mitigate any harmful effects of an unauthorized use or disclosure and will be reported to the St. Peter's Privacy Officer or Corporate Compliance Officer.

Student Name _____

Responsible Physician (Must be a member of the active staff)

_____

Printed name of sponsoring physician

Signed the _____ day of _____, 20____