MOUNTAINSTAR
St. Mark's Hospital

Student Profile & Checklist

Name (First, Middle Initial, Last): _____ Gender: _____

Preferred First Name (if different from legal name): _____

Permanent Address: _____ City: _____

State: _____ Zip: _____ Phone Number: _____

Personal Email Address: _____

School Email Address: _____

Employed by HCA? Yes ___ No ___ If yes, where? _____ 3-4 ID _____

Educational Institution: _____ Program: _____

Course Name: _____ Estimated graduation date: _____

Instructor Name: _____ Hospital Unit/Area Assigned: _____

From: ____/____/____ To: ____/____/____Total hours required for this rotation: _____

In case of Emergency, please notify:

Name: _____ Home Phone: _____

Cell/Work Phone: _____Relationship to Student: _____

Documentation:

	Student Orientation Booklet Post Test Answer Sheet
	Statement of Responsibility
	Confidentiality & Security Agreement
	Student Health Questionnaire with supporting documentation
	Parking Policy Agreement
	Code of Conduct Certificate (Only for students with rotation hours $\geq$ 160)

Knowledge Review
Student Orientation Handbook

Name:_____

(Please Print Your Name)

Check the correct multiple choice answer

1. A ___ B ___ C ___ D ___
2. A ___ B ___ C ___ D ___
3. A ___ B ___ C ___ D ___
4. A ___ B ___ C ___ D ___
5. A ___ B ___ C ___ D ___
6. A ___ B ___ C ___ D ___
7. A ___ B ___ C ___ D ___
8. A ___ B ___ C ___ D ___
9. A ___ B ___ C ___ D ___
10. A ___ B ___ C ___ D ___
11. A ___ B ___ C ___ D ___
12. A ___ B ___ C ___ D ___
13. A ___ B ___ C ___ D ___
14. A ___ B ___ C ___ D ___
15. A ___ B ___ C ___ D ___
16. A ___ B ___ C ___ D ___
17. A ___ B ___ C ___ D ___
18. A ___ B ___ C ___ D ___
19. A ___ B ___ C ___ D ___
20. A ___ B ___

I have received a copy of the Student Orientation Handbook and have read it and been allowed to ask questions. I am familiar and comfortable with the contents of the Student Orientation Handbook.

Signature: _____ Date: _____

EXHIBIT A

STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided the undersigned in the form of experience in a clinical setting at _____ ("Hospital"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks and be solely responsible for any injury or loss sustained by the undersigned while participating in the Program operated by: _____ ("School") at Hospital unless such injury or loss arises solely out of Hospital's gross negligence or willful misconduct.

_____ _____

Signature of Program Participant/Print Name Date

_____ _____

Parent or Legal Guardian Date
If Program Participant is under 18 / Print Name

EXHIBIT B

Confidentiality and Security Agreement

I understand that the Hospital or business entity (the "Hospital") for which I work, volunteer or provide services manages health information as part of its mission to treat patients. Further, I understand that the Hospital has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Hospital must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning information, or any information that contains Social Security numbers, health insurance claim numbers, passwords, PINs, encryption keys, credit card or other financial account numbers (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at the Hospital, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job related duties in accordance with the Hospital's Privacy and Security Policies, which are available on the Hospital intranet (on the Security Page) and the Internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information or Hospital systems.

General Rules:

1. I will act in the best interest of the Hospital and in accordance with its Code of Conduct at all times during my relationship with the Hospital.
2. I understand that I should have no expectation of privacy when using Hospital information systems. The Hospital may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.
3. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within the Hospital, in accordance with the Hospital's policies.

Protecting Confidential Information:

1. I understand that any Confidential Information, regardless of medium (paper, verbal, electronic, image or any other), is not to be disclosed or discussed with anyone outside those supervising, sponsoring or directly related to the learning activity.
2. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it. I will not take media or documents containing Confidential Information home with me unless specifically authorized to do so as part of my job. Case presentation material will be used in accordance with Hospital policies.
3. I will not publish or disclose any Confidential Information to others using personal email, or to any Internet sites, or through Internet blogs or sites such as Facebook or Twitter. I will only use such communication methods when explicitly authorized to do so in support of Hospital business and within the permitted uses of Confidential Information as governed by regulations such as HIPAA.
4. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized. I will only reuse or destroy media in accordance with Hospital Information Security Standards and Hospital record retention policy.
5. In the course of treating patients, I may need to orally communicate health information to or about patients. While I understand that my first priority is treating patients, I will take reasonable safeguards to protect conversations from unauthorized listeners. Whether at the

School or at the Hospital, such safeguards include, but are not limited to: lowering my voice or using private rooms or areas (not hallways, cafeterias or elevators) where available.

6. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information. I will not access data on patients for whom I have no responsibilities or a need-to-know the content of the PHI concerning those patients.
7. I will not transmit Confidential Information outside the Hospital network unless I am specifically authorized to do so as part of my job responsibilities. If I do transmit Confidential Information outside of the Hospital using email or other electronic communication methods, I will ensure that the Information is encrypted according to Hospital Information Security Standards.

Following Appropriate Access:

1. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
2. I will only access software systems to review patient records or Hospital information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Hospital information, I am affirmatively representing to the Hospital at the time of each access that I have the requisite business need to know and appropriate consent, and the Hospital may rely on that representation in granting such access to me.

Using Portable Devices and Removable Media:

1. I will not copy or store Confidential Information on removable media or portable devices such as laptops, personal digital assistants (PDAs), cell phones, CDs, thumb drives, external hard drives, etc., unless specifically required to do so by my job. If I do copy or store Confidential Information on removable media, I will encrypt the information while it is on the media according to Hospital Information Security Standards
2. I understand that any mobile device (Smart phone, PDA, etc.) that synchronizes Hospital data (*e.g.*, Hospital email) may contain Confidential Information and as a result, must be protected. Because of this, I understand and agree that the Hospital has the right to:
    a. Require the use of only encryption capable devices.
    b. Prohibit data synchronization to devices that are not encryption capable or do not support the required security controls.
    c. Implement encryption and apply other necessary security controls (such as an access PIN and automatic locking) on any mobile device that synchronizes Hospital data regardless of it being a Hospital or personally owned device.
    d. Remotely "wipe" any synchronized device that: has been lost, stolen or belongs to a terminated employee or affiliated partner.
    e. Restrict access to any mobile application that poses a security risk to the Hospital network.

Doing My Part – Personal Security:

1. I understand that I will be assigned a unique identifier (*e.g.*, 3-4 User ID) to track my access and use of Confidential Information and that the identifier is associated with my personal data provided as part of the initial and/or periodic credentialing and/or employment verification processes.
2. I will:
    a. Use only my officially assigned User-ID and password (and/or token (*e.g.*, SecurID card)).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
3. I will never:

a. Disclose passwords, PINs, or access codes.
b. Use tools or techniques to break/exploit security measures.
c. Connect unauthorized systems or devices to the Hospital network.

4. I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords, positioning screens away from public view.
5. I will immediately notify my manager, Hospital Information Security Official (FISO), Director of Information Security Operations (DISO), or Hospital or Corporate Client Support Services (CSS) help desk if:
    a. my password has been seen, disclosed, or otherwise compromised;
    b. media with Confidential Information stored on it has been lost or stolen;
    c. I suspect a virus infection on any system;
    d. I am aware of any activity that violates this agreement, privacy and security policies; or
    e. I am aware of any other incident that could possibly have any adverse impact on Confidential Information or Hospital systems.

Upon Termination:

1. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Hospital.
2. Upon termination, I will immediately return any documents or media containing Confidential Information to the Hospital.
3. I understand that I have no right to any ownership interest in any Confidential Information accessed or created by me during and in the scope of my relationship with the Hospital.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Signature	Hospital Name and COID	Date
Printed Name	Business Entity Name	

MOUNTAINSTAR
St. Mark's Hospital

Student Health Questionnaire

NAME: _____ BIRTHDATE: _____

ADDRESS: _____

CITY: _____ PHONE: _____

EDUCATIONAL INSTITUTION: _____

Please answer the following questions and either attach appropriate documentation or work with your educational institution to provide documentation.

1. Are you physically able to complete your clinical rotation?

   Yes ____ No ____ If no, describe _____

2. I have Varicella (Chicken-Pox) immunity in the form of one of the following:
   a. Two Varicella vaccinations at least 4 weeks apart, OR
   b. Positive Varicella titer.

   Yes ____ (*Attach documentation)* No ____

3. I have Measles, Mumps, and Rubella immunity in the form of one of the following:
   a. Two MMR vaccinations at least 4 weeks apart, OR
   b. Positive Rubella and Rubeola titers.

   Yes ____ (*Attach documentation)* No ____

4. If patient contact anticipated; please provide documentation of Hepatitis B immunization or signed declination of vaccine form.

5. Have you ever had a positive reaction to a TB (PPD) skin test?

   Yes ____ No ____

   *If "YES": Attach copy of a normal chest x-ray taken within the last 12 months, OR documentation as a previous positive reactor.

   *If "NO": Attach copy of negative TB Skin Test completed within 12 months, OR negative QuantiFERON Gold or T-SPOT blood test completed within 12 months.

6. If your clinical rotation falls between October 1st and March 31st (or dates defined by the CDC); please provide documentation of a current/annual Influenza Vaccination or a signed declination of vaccine form. *(If you sign the influenza declination form, you will be required to wear a surgical mask while in patient care areas).*

7. Please provide documentation of a negative Drug and Alcohol screening completed with 12 months which includes (at a minimum) alcohol, amphetamines, barbiturates, benzodiazepines, opiates, marijuana, methadone, cocaine, meperidine and fentanyl analogues.

DECLINATION FORM FOR SEASONAL INFLUENZA VACCINE

Name (printed):_____ Facility: St Mark's Hospital

St Mark's Hospital has recommended that I receive influenza vaccination in order to protect myself and the patients I serve.

I DO NOT WANT A FLU SHOT. I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for this season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination form.

I am declining due to the following reasons (check all that apply):

___ I have already been vaccinated for the **current** season.

___ I believe I will get influenza if I get the vaccine.

___ I do not like needles.

___ My philosophical or religious beliefs prohibit vaccination.

___ I have an allergy or medical contraindication to receiving the vaccine.

___ I do not wish to say why I decline.

___ Other reason – please tell us. _____

- I understand that if I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season.
- I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available.
- I have read and fully understand the information on this declination form.

_____	_____	_____
Printed Name	Signature	Date

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DECLINATION - HEPATITIS B IMMUNIZATION

Due to the potential occupational exposure to blood and other potentially infectious materials you may be at risk for acquiring Hepatitis B Virus (HBV) infection.

Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. 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.

_____	_____	_____
Printed Name	Signature	Date

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St. Mark's Hospital Student Parking Policy

Scope: Students doing clinical experiences at St. Mark's Hospital

Purpose: To provide convenient and adequate parking spaces for all by designating areas on the hospital campus for various populations. Appropriate parking by students and employees makes for easier and convenient parking for patients and visitors.

Policy: Students follow the same parking policy that applies to employees and is found on the Grapevine (hospital's intranet page); Policies and Procedures; Parking.

On Monday through Friday, students can park in the East Parking Garage (the corner of 3900 South and 1300 East) on the 3rd level. Students may also park in the southwest parking area in the last several rows that have stars painted on the stalls.

Students found parking in unauthorized spaces are subject to having their cars immobilized and a fee of $80 in cash to have their car released.

On Saturdays and Sundays, students can park on all levels of the East Parking Garage and in the southwest parking lot behind the hospital.

I understand and agree to comply with the Student Parking Policy:

_____ _____

Student Signature Date