Please type except for signatures – incomplete forms will be returned.

NCH Healthcare System

Application and Verification of Medical Student Readiness for Clinical Training

Provide a color photo in .jpeg format

Basic Information

Full Name:
AAMC ID:
Current Address:
Cell phone number:
E-mail Address:
Emergency Contact (name and phone number):
Medical School:
Rotation name and date range:
Number of hours per week on rotation:
School Contact (name and phone number):

Identification Data

Last four digits of social security number:
Date of Birth:
Gender: M F
Attach a valid picture ID issued by a state, federal, or regulatory agency (driver's license is acceptable).

Check the box to indicate that supporting information is on file at the school

- ☐ Medical School Transcripts that document readiness for clinical rotations
- ☐ Curriculum Vitae (CV)
- ☐ Evidence that student has completed all immunization requirements per the AAMC Standard Immunization Form, and proof of the COVID-19 vaccine (please attach)

Circle "Yes" or "No" and fill in other information as requested

This student is in good academic standing at this institution. Yes No
Medical liability and/or malpractice insurance will be provided by the home school: Yes No
Aggregate Insurance limit: Per Instance Insurance limit:
Online policy URL:
Policy expiration date:
This student holds current ACLS certification. Yes No Date expires:
This student holds current BLS certification. Yes No Date expires:
This student has personal health insurance: Yes No
A complete immunization record (AAMC form) is available for review at any time. Yes No
Date of last PPD placement:
Date of last flu vaccine:
Mask fit test completed: Yes No
This student has passed a drug screen for illegal substances at our institution on _____
This student has completed a criminal background check at our institution on _____
This student is fully vaccinated against COVID-19. Yes No
This student has complied with HIPAA training requirements. Yes No

Signature of Medical School Representative_____ Date_____

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Completed by NCH Medical Education Office: Mandatory NCH modules completed on_____

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NCH Healthcare System

Medical Student Description of Approved Learning Activities Form

Medical Student: _____ Medical School: _____

Rotation: _____ Rotation Dates: _____

Please read the statements below and provide your signature at the bottom to indicate your agreement and understanding of the approved learning activities.

1. At all times wear a clearly visible NCH name badge and badge hanger, which identifies you as a medical student.

2. Introduce yourself to patients and staff as a medical student being supervised by "Dr.'s Name" (supervising or resident physician) and interact only with those patients admitted to or being cared for by the attending/resident physician.

3. All clinical activities must be performed under the direction and guidance of the attending or resident physician.

4. Any involvement in routine, invasive procedures must take place under the *direct supervision* of the attending and/or resident physician. These include minor suturing, OR activity, Foley insertion, starting of IV, and casting.

5. Medical students are expected to collect clinical and laboratory data for presentation to the attending/resident and assist the attending/resident physician with routine patient rounds.

6. Medical students may perform a patient history and examination (PFSH and/or ROS), and document their findings in the student section of the medical record which will be review later for educational purposes.

7. The medical student note may NOT be referred to in the physician's personal note, nor substituted for the physician note.

8. Medical students can NOT provide orders, written or verbal.

9. Medical students can NOT admit patients to the hospital. The admission note is the full responsibility of the attending/resident physician and may not be made by or on the order of the medical student.

10. Medical students will receive training on the Electronic Medical Record System (EMR) at the beginning of their assignment and complete several NCH modules concerning patient safety/general safety precautions, relevant rules and regulations, and professionalism.

11. Rounds and medical record entries in the EMR by the medical student shall not substitute for physician rounds or medical record entries.

12. Medical students must use their assigned username and password to access EMR documentation. Entering documentation under another provider's username and password is considered fraud.

I, the undersigned medical student, request the specifically indicated learning activities as outlined above. No learning activities are requested that do not appear on this form and I understand the granting of such learning activities is subject to verification of my current competency, training and experience. I also recognize that, ultimately, I have no hospital clinical privileges, only the privilege of accompanying and observing my assigned clinical team per these general terms.

_____ _____

Signature of Medical Student Date Signed

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CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

In addition to the NCH Orientation which includes information on Confidentiality and Non-Disclosure policies of NCH Healthcare System, throughout my learning experience with the hospital system, I will keep all information that I see and hear confidential.

As a condition to receiving access and/or being granted authorization to access any form of confidential information within the hospital system, I, the undersigned, agree to comply with the following terms and conditions. In addition, if I am an NCH employee but functioning as a student for clinical rotations under the terms of this *Healthcare Students Policy,* I understand that my NCH employee sign-on access may be used ONLY during paid working hours and my student sign on must be used when performing duties as a student.

1. I will utilize and access only information necessary for performance of my duties. In addition, I will not access any other confidential information including personnel, billing or private information.
2. My Sign-On Code is equivalent to my Legal Signature and I will not disclose this code to anyone or allow anyone to access the system using my Sign-On Code.
3. I am responsible and accountable for all entries made and all retrievals accessed under my Sign-On Code, even if such action was made by me or by another due to my intentional or negligent act or omission. Any data available to me will be treated as confidential information.
4. I will not attempt to learn or use another's Sign-On Code.
5. **I will not access any on-line computer system using a Sign-On Code other than my own**.
6. If I have reason to believe that the confidentiality of my user Sign-On Code/password has been compromised, I will immediately change my password and notify NCH Healthcare System's Privacy Officer of the suspected security breach.
7. I will not disclose any confidential information unless required to do so in the official capacity of my employment or contract. I also understand that I have no right or ownership interest in any confidential information.
8. I will not leave a secured computer application unattended while signed on. I understand I am responsible if another individual accesses confidential information using my Sign-On Code.
9. I will comply with all policies and procedures and other rules of the NCH Healthcare System relating to confidentiality of information and Sign-On Codes.
10. I understand that my use of the system will be periodically monitored to ensure compliance with this agreement.
11. I will not disclose protected health information or other information that is considered proprietary, sensitive, or confidential unless for treatment, payment or other healthcare operations.
12. I understand that information accessed via any data source contains sensitive and confidential patient care, business, financial and employee information, which should only be disclosed to those authorized to receive it.
13. I agree that disclosure of confidential information is prohibited indefinitely, even after termination of my business relationship, unless specifically waived in writing by the authorized party.
14. I will respect the confidentiality of any reports and handle, store and dispose of these reports appropriately.
15. I will not install or operate any non-licensed software on any computer within NCH Healthcare System.
16. I understand I will not access my personal medical record and that access to my personal records can be obtained through the Health Information Management department. I understand that I do not have permission to review any family member's record.
17. This agreement shall survive the expiration of my business relationship.
18. The use of the NCH Healthcare System Internet Connection is owned and controlled by the NCH Healthcare System and my user privilege may be revoked at any time, for any reason, and my abuse or improper usage may be the basis for corrective action, including dismissal from the clinical rotation program, and/or subject me to legal action.

STUDENT SIGNATURE: _____Date:_____

Student Name (Please Print): _____