ARCHBOLD

Clinical Rotation/Preceptorship Clearance Packet

Access for students is only granted for ONE quarter/semester. A new request must be submitted each quarter/semester.
*****Please allow 2 weeks for account creation*****

1) Please check one of the following:

- [x] New student account
- [ ] Returning student account
- [ ] Correct existing account
- [ ] Account deletion

2) System access requested:

- [ ] NO ACCESS NEEDED
- [x] Soarian Clinicals
- [x] MAK
- [ ] PICIS
- [ ] Perigen
- [ ] NextGen
- [ ] SIS
- [ ] Other: _____

3) STUDENT- Please complete the following:

Student Full Name: Kasey (First) Michelle (Middle) Smith (Last)

Student ID Number: 12345678 School: Archbold University

4) INSTRUCTOR – Please complete the following:

Academic Instructor Name: Kasey Smith
Academic Instructor Email: kmsmith@archbold.org
Academic Instructor Contact Number: 269-228-8014

5) Please check one of the following:
Course of Study:

- [x] RN
- [ ] LPN
- [ ] Respiratory Therapy
- [ ] EMT/Paramedic
- [ ] Radiology
- [ ] Laboratory
- [ ] Surgical Tech
- [ ] Cardiovascular Tech
- [ ] Sonography
- [ ] Physical Therapy
- [ ] Occupational Therapy
- [ ] Speech Therapy
- [ ] Exercise Physiology
- [ ] Social Work/Case Management
- [ ] Medical Records
- [ ] Business Management
- [ ] Medical Student (MD/DO)
- [ ] Pharmacy
- [ ] Dietician

Student Clinical/Preceptorship Clearance Checklist

☑ Orientation Packet Reviewed & Signed Date Completed: 9-10-2021

- Includes:
  - About Archbold Medical Center
  - Mission, Vision, & Core Values
  - Maintaining Patient Confidentiality
  - Media, Social Media, & Electronic Communication
  - Hardwiring Service Excellence
  - Customer Service & Communication
  - Infection Control/Prevention & Student Health
  - Patient Safety
  - Student Safety & Security
  - Emergency Preparedness & Fire Safety
  - Student/Instructor Parking
  - Dress Code
  - Miscellaneous: Smoking, cafeteria hours, etc.
  - Student Clinical Policy

☑ Completed "Student Information Sheet"

☑ Signed "Confidentiality and Non-Disclosure Agreement"

☑ Signed Attestation Statement

☐ Special Accommodations listed here:

N/A

By signing this form I certify that I have reviewed the information within this packet and that it is correct, to the best of my knowledge.

Student Signature: Kasey Smith Date: 9-10-2021

Academic Instructor Signature: [signature] Date: 9-10-2021

Student Information Sheet

General Information:

Name: Kasey Smith Contact Number: 229-228-8014

Address: 1234 Gordon Avenue

City: Thomasville State: GA Zip Code: 31792

Emergency Contact:

Name: John Smith

Relationship: Spouse

Contact Number: 229-555-1234

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

WITH EMPLOYEES AND OTHER WORKFORCE MEMBERS OF ARCHBOLD*

As an employee, student, volunteer, or other member of Archbold's Workforce/Medical Staff, I acknowledge that I have completed training on the Medical Center's Health Insurance Portability and Accountability Act ("HIPAA") privacy/security policies and the HIPAA privacy/security and breach notification regulations.

1. I understand that all patient and business information, in any format, is confidential, and I will access and use this informational only when necessary to perform my job-related duties. I will keep such information confidential. This information includes but is not limited to clinical treatment, demographic, billing, financial, and identifiable information also known as Protected Health Information or "PHI."

2. I agree to respect and abide by all federal, state and local laws pertaining to the confidentiality of identifiable medical, personal, and financial information. I understand that I could be held civilly and criminally liable (through monetary fines and/or imprisonment) for improper use or disclosure of patient personal, financial, or medical information.

3. I agree to adhere to all policies and procedures adopted by the Medical Center to comply with HIPAA governing the privacy, security and the use/disclosure of protected health information and corresponding breach notification regulations.

4. I will secure my computer workstation at all times and practice good workstation security measures by logging out of applications and locking my workstation when my workstation is unattended. I understand if I use a workstation that is accessible to other users, I need to log out of any open applications before simply locking the workstation. I understand that, as a requestor of access or user of Archbold's Information System, my computer login ID is the equivalent of my legal signature, and I will be accountable for all representations made at log in and for all work done under my login ID.

5. I will safeguard my computer login ID and password at all times. If I believe the security of my login ID and password has been compromised, I will immediately change it through the Archweb self-service portal or contact Information Systems at 229-228-2959 to have my password changed. I understand that Archbold audits access and use of its Information Systems.

6. I understand any security token/FOB used to remotely access Archbold's information systems is to be used only by me. I am not to give this remote access token to any other individual.

7. I will not access patient information regarding myself, family members, or friends. I understand that I may access my information from Archbold patient portals or follow established Medical Record Department procedures to obtain clinical information from my medical record—just as any other patient does.

8. I understand that the misuse of my access to the computer systems of the Medical Center (including accessing my own records, my family/friends' records or snooping), or of confidential information obtained, may subject me to disciplinary action up to and including termination of my access rights or my employment.

9. I understand I am only to discuss patient information with other workforce members who need to know that information to do their job. I understand I am not to discuss or disclose patient information outside the organization.

10. If I am a workforce member, I understand specific administrative policies and procedures exist regarding the release of medical record information and release of patient condition information. Only designated individuals may disclose such information in accordance with specified procedures in Administrative Policies #105.06, "Release of Protected Health Information" and #101.02, "Release of Patient Condition Information."

11. I understand and agree that my obligation to protect the confidentiality of patient and business information extends even after I terminate my employment or other relationship with the Medical Center.

12. I understand paper documents, CDs, and any documents containing PHI are to be placed in secure shred bins and are not to be discarded in regular trash.

13. I agree not to disclose patient information on any Internet-based websites or social media websites, including but not limited to, Facebook, Twitter, YouTube,Dropbox, or any online document storage application. I understand that any patient information (even where the patient's name is not used) is confidential and is not to be disclosed in any manner to any outside party or to any workforce member unless that workforce member needs to know that information to do their job.

14. I understand that, unless I am specifically authorized to do so by Administration, I am not to photograph, record, videotape or make any audio recording of any meeting or conversations whether patient or business related between employees, physicians, patients, family members or guests. If in the course of my job responsibilities my personal cellular device is authorized for use by Archbold for treatment, payment, or operational activities, I am only to use it for designated communication purposes with designated, secure communication applications for needed treatment, payment, or operational communications.

15. I agree not to send, forward, copy, print, download or otherwise remove or disclose PHI outside Archbold without express written permission of my supervisor.

16. I agree to encrypt (use "Archsafe") on all outgoing emails sent for treatment, payment or operational purposes that contain protected health information.

17. I agree not to email PHI to private email addresses and not to save PHI to unencrypted drives, laptops, CDs, phones, other portable devices, etc. I understand I am to save business and patient information to secure network drives and not to my local workstation drive.

18. I will not alter, destroy, copy, sell, or in any way use any PHI except as properly authorized.

19. I understand if I have any questions or concerns about privacy and security of patient information and/or the proper use or disclosure of patient information, I am to discuss these with my Supervisor or Archbold's Privacy Officer/Compliance Officer at 229-228-2928 or call the Compliance Voice Mailbox at 229-228-8443.

20. I agree to report immediately any and all potential privacy or security incidents or breaches or any unauthorized/inappropriate access, use or disclosure of patient protected health information to the Archbold HIPAA Privacy Officer at 229-228-2928, or Information Services at 229-228-2959 as a condition of my job responsibilities.

Signature: _____

Name: Kasey Smith
(Print)

Date: 9-10-2021

Department: Nursing

***"Archbold" means (1) John D. Archbold Memorial Hospital, Inc.**, which includes John D. Archbold Memorial Hospital, Grady General Hospital, Brooks County Hospital, and Mitchell County Hospital, and all of their on-campus and off-campus provider-based departments, facilities, and rural health clinics, Archbold Northside Center for Behavioral & Psychiatric Services facility, Glenn-Mor Nursing Home, Mitchell Convalescent Center, and Pelham Parkway Nursing Home; **(2) Archbold Medical Group, Inc.**, which includes Archbold's physician practices; **and (3) Archbold Health Services, Inc.**, which includes, but is not limited to, Archbold's retail pharmacy, home health, and hospice providers. **Please visit our website, at www.archbold.org (at the "Locations" tab) for more information regarding Archbold providers and locations.**

ARCHBOLD

ATTESTATION STATEMENT

Program Participant (Student): Kasey Smith	Program Participant Phone Number: 229-555-1234
Academic Institution: Archbold University	Program: RN
Academic Instructor: Kasey's Instructor	Instructor Phone Number: 229-555-1234
Rotation Start Date: 1-1-2021	Rotation End Date: 12-31-2021

On behalf of the listed Academic Institution, the undersigned acknowledges and attests that the Program Participant has met all of the following requirements:

✓ Student Liability Insurance

☑ Immunizations

- Proof of Measles, Mumps and Rubella (MMR) immunity by positive antibody titers or 2 doses of MMR
- Proof of 3 doses of Hepatitis B vaccine, positive titer, or signed declination
- Proof of 2 doses of Varicella vaccine or positive titer

☑ Influenza Vaccine

- Proof of seasonal influenza vaccine during influenza season (October 1st- March 31st) of current year

☑ PPD/Chest X-Ray

- Proof of negative TB skin test within 1 year or negative CXR (if had a positive PPD) within 2 years. If history of a positive TB skin test or CXR then the individual is cleared by a Tuberculosis Screening Questionnaire indicating no problems for more than 3-4 months from a physician/ health care professional.

☑ Basic Life Support (BLS) Certification

☑ Pre-employment Background Check (within 2 years) that includes :

- Statewide criminal history in every state where Program Participant has resided
- Does not reveal any criminal conviction or pending investigations, reviews, sanctions, or peer review
- Confirms the individual is not listed as a violent sexual offender
- Does not reveal any limitations of any licensure, certifications, or registration
- Confirms that Program Participant has not been convicted of, pled "no contest" to, or had adjudication deferred or withheld for any violation of federal, state, county or municipal law, other than criminal traffic offenses within the past 7 years
- **Advanced background checks are required for Program Participants who complete clinical time in the Long-Term Care Facilities**

Please circle one: Released in PreCheck and reviewed by AMC *OR* Reviewed by Academic Institution

☑ Drug Screen (within 2 years):

- Program Participant has satisfactorily completed a standard 10 panel drug screen which does not reveal information of concern or inappropriate use of drugs.

Please circle one: Released in PreCheck and reviewed by AMC *OR* Reviewed by Academic Institution

This Attestation Form is provided in lieu of providing individual records or the various screenings and requirements referred to above. Archbold Medical Center may rely on this Attestation as if all documentation was provided. The Academic Institution shall provide proof of any of the items listed within this attestation statement should Archbold Medical Center be audited by a regulatory or accrediting agency. Archbold Medical Center reserves the right to perform a separate audit and the Academic Institution must provide verification within a 24-hour timeframe. The Academic Institution acknowledges that any Program Participant may be suspended or removed from participation in the Program at the discretion of Archbold Medical Center until any deficit is rectified.

The undersigned is authorized to sign this attestation on behalf of the Academic Institution listed.

Kasey's Instructor
Signature

9-10-2021
Date

Kasey's Instructor
Title

Archbold University
Academic Institution

kmsmith@archbold.org
Email

229-228-8014
Phone Number