Clinical Documentation Verification Checklist
For Students

Providence HEALTH

Student name:_____

Immunization Record to include:		**Dates**
HEP B series *(Clinical areas)*	1st	_____
	2nd	_____
	3rd	_____
	Titer:	_____
Influenza *(All areas between October 1 and March 31 annually)* Attach proof of vaccine or declineation letter	Date:	_____
	Declined:	_____
Measles, Mumps, Rubella *(All areas)*	1st	_____
	2nd	_____
Rubella Titer:	Date:	_____
PPD/TB Screening or **T-Spot** *(Both steps required within past 12 months)*	1st Step (PPD)	_____
	2nd Step(PPD)	_____
or	T-Spot	_____
Tetanus *(All areas)*	Date:	_____
Varicella *(All areas)*	Date:	_____
Drug Screen *(All areas)*	Date:	_____
OIG and Background Check to include: -Check for places of residence for prior 7 years -Check for Sex Offender Registry -Check of the office of Inspector General -Check of the General Services Administration (GSA) list of excluded individuals/entities *(All areas)*	Date:	_____
CPR/BLS *(For clinical and patient care areas)*	Expires:	_____

Select One:

☐ The student's documents listed above are maintained on file at the College and may be requested if needed.

☐ The student completed the documents above and will provide copies to the hospital coordinator before beginning the rotation.

_____ _____ _____

College Instructor/Coordinator Signature | Date | College

Providence
HEALTH

Conditions of Participation
Providence Health

I,_____, acknowledge that I am a student at _____ College/University and that I am fully qualified to participate in a work experience event at Providence Health.

I agree to abide by the following conditions of participation:

1. I agree to complete all required homework/self study assignments according to assigned time frames.
2. I agree to abide by all Hospital policies, including those pertinent to safety, infection control, dress code, security, drug and health care screenings, patient care (as applicable) and conduct.
3. If my clinical experience involves direct patient care, I agree to provide the Hospital with documentation of (non-reactive) tuberculin skin testing within the past year. In the event that I do not have such documentation, I agree to submit to a PPD Tuberculin Skin Test.
4. I agree to submit to drug testing at any time if required by Providence.
5. I am not actively infected with any communicable or infectious disease. I will promptly inform Providence Health should I be exposed to any communicable or infectious disease, regardless of where this exposure occurs.
6. I agree to perform only the duties to which I am assigned and only under the supervision of designated hospital and/or instructional staff.
7. Should I sustain an "on the job" injury, I understand that I am not covered by the Hospital's worker's compensation program nor by any Providence Health benefit program including health insurance.
8. In the event of injury, I understand that I may seek Hospital emergency department services, in which case routine emergency department charges will be applied.
9. I agree that I or the school must provide and maintain professional liability insurance in amounts satisfactory to Providence Health, before I may begin my work experience and throughout my work experience inform Providence Health.
10. I agree to immediately disclose to Providence any debarment, exclusion or other event that makes me an ineligible person with respect to participation in any federal health care program.
11. I agree to participate in any orientation and work experience required by Providence, including Life Safety Training.

I have read this document, have had an opportunity to ask questions, and I fully understand its contents. I am signing this document freely and voluntarily.

_____
Signature of Student/Date

_____
Witness/Date

Note: Each student participating in a Work Experience Event at Providence Health is required to agree to the following Conditions of Participation, which are incorporated as an Addendum to all Work Experience Agreements. The terms of this Conditions of Participation are not intended to form any employment relationship of any kind between Student and Providence, and Providence may revoke Student's participation in the Program at any time for any reason.

Providence
HEALTH

CONFIDENTIALITY STATEMENT

I,_____, do hereby affirm that I will not discuss, reveal, copy, or in any manner disclose the identity or health information of any patient who has received or is receiving healthcare services from Providence Health. I understand that it is illegal for me to divulge any patient-specific information in any form to any person not involved in providing health-related services to a patient at Providence Health.

I understand that all patient information, including but not limited to verbal, written, and electronic information, is confidential. Both federal law and South Carolina state laws and regulations protect all information, including the identity of patients.

I hereby acknowledge and agree that I shall at all times comply with all applicable laws, including the Medical Records Security and Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and keep all patient-specific information absolutely confidential.

I understand that reading, discussing, or otherwise using patient-specific identification and health information for other than legitimate healthcare purposes is grounds for immediate dismissal and possible legal action, including both civil lawsuits and criminal penalties.

_____ _____
Student Signature Parent/Guardian (Please print)

_____ _____
Date Parent/Guardian - Signature and Date

_____
Name of School

_____ _____
Date Providence Student Coordinator (signature)

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Providence HEALTH

Student Data Sheet- College Students

Last Name:	**First Name:**	**Middle initial:**
Address:	**City:**	**State:**
Zip Code:	**Phone Number:**	**Email address:**
Assigned Department:	**College:**	**Major:**
Clinical Start Date:	**Clinical End Date:**	**Total hours:**

Day of the week in Hospital (Check all that apply):

☐ SUN ☐ MON ☐ TU ☐ WED ☐ TH ☐ FRI ☐ SAT

Daily hours:

Instructor Name/College Contact:

Online Module Completed: **Hospital Orientation Date:**

☐ Student Passport ☐ Providence LifeTalent

Student Signature:

Date of Signature: