Southeast HEALTH

Dear Student:

Thank you for your interest in Southeast Health Medical Center. Attached is our student application. You will need to return the following information to Undergraduate Medical Education to be approved:

1. Current affiliation agreement from your school.
2. A letter from your Program Director to include the following:
    a. Verify you are in good standing
    b. Approval, naming the specific rotation(s) and timeframe of rotation
    c. Describe specifics of your liability coverage; Cert. of Insurance (COI).
3. Completed Application with signatures (attached).
4. Signed Information Access Security & Patient Confidentiality Agreement.
5. Signed Compliance Code of Conduct Form.
6. Immunization Records including Current TB results (PPD)
7. ACLS/BCLS certificates
8. Current resume and/or CV
9. Signed Scope of Practice
10. Health Insurance Card
11. Student picture for ID badge (Jpeg or PDF).
12. Fit Mask testing documentation
13. Flu Vaccine documentation (REQUIRED)
14. Orientation requirements

All the above items should be completed and returned a minimum of two (2) months prior to beginning your rotation. Please forward all completed materials and/or questions that you might have to me.

Thank You,

Judy Higby

Judy Higby, CPCS
Clinical Education Coordinator, Southeast Health
1108 Ross Clark Circle
Dothan, AL 36301
334/712-3329 x2061 phone
334/678-2893 fax
johigby@samc.org

Southeast HEALTH

I. Identifying Information			
Last Name (as it appears on license):	First Name:		Middle Initial
Social Security#	Gender ☐ Male ☐ Female	Date of Birth:	
Home Telephone:	Mobile phone:		
E-Mail Address:			
Home Address: (Local if Possible)	City:		
	State:	Zip Code:	
Primary Clinical Affiliation: ☐ Medical Student ☐ PA ☐ NP			

II. Emergency Contact --Please immediately notify Medical Staff Services of any changes.	
Name and Relationship:	
Home Telephone:	Cell phone:

III. Education Information
Name of School:
Address:
Phone Number:
Program Director Name and Email Address:
Month and Year of Graduation

IV. Rotation Request and Supervising Physician
Rotation Type: ☐ Emergency Medicine ☐ Family Medicine ☐ Internal Medicine ☐ OB/GYN ☐ Pediatrics ☐ Psychiatry ☐ Surgery ☐Other _____
Rotation Date: From: _____ To: _____ (M/D/Y) (M/D/Y)
Supervising Physician on Staff: (NP & PA only)

Southeast HEALTH

Specialty of Supervising Physician:
Supervising Contact Telephone Number:

APPLICANT'S CERTIFICATION

I hereby certify that the information I submit in the application is complete and correct to the best of my knowledge and belief.

Signature Applicant _____ Date _____

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STATEMENT OF SUPERVISING PHYSICIAN

I (my designee) understand that at no time may this student perform functions that would constitute medical practice and that all duties performed by him/her must be done under my (my designee's) supervision and upon my (my designee's) authority. I (my designee) assume all responsibility and liability for his/her actions while providing service to my (my designee's) patients and accountability for his/her conduct within Southeast Health Medical Center.

I (my designee) understand that all orders and drafts of dictated histories and physicals and/or discharge summaries (if applicable to the services granted) must be authenticated by me/my designee within 24 hours.

I (my designee) understand that I (my designee) am responsible for the accuracy, completeness, timeliness, legibility and authenticity of all documents.

Signature of Sponsoring Physician _____ Date _____

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REVIEW/APPROVAL

GME Director _____ Date _____

This form must be completed for each rotation

Southeast HEALTH

Compliance Code of Conduct

Ethical conduct is the highest form of loyalty to Southeast Health Medical Center (the "Medical Center"). We at the Medical Center have always taken pride in the ethical conduct of our employees and colleagues -- in their honesty, their fairness, and their integrity. The success of the Medical Center depends on such behavior. It makes us more economically efficient, makes working with one another more enjoyable, and enhances our reputation with our customers and the public at large.

Part of being an ethical employee/colleague means carefully following all rules, laws, and regulations that govern your job and your work place. Therefore, it is the Medical Center's policy that you must learn about and conscientiously follow the laws and regulations that affect your job. It is very important that you learn and fully understand these rules and carefully read any written instructions that you receive in the course of your job. If you have questions, please ask your supervisor.

Finally, because we at the Medical Center work as a team and because as a team we rely upon one another and are responsible for one another, it is also the Medical Center's policy that you shall report to your superiors if you become aware of any possible violation of any rules and regulations.

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read the CODE OF CONDUCT and that I agree to abide by it.

Signature: _____

Print Name: _____

Date: _____

Southeast HEALTH

Information Access Security & Patient confidentiality Agreement

The undersigned agrees and commits to the following statement:
Southeast Health Medical Center respects the confidentiality of our patient's medical information. We believe that patients have the right to have their medical information used appropriately for their care and to expect that caregivers will carefully protect the privacy of that information.

The HIPAA Privacy and Security Standards, HITECH Act of 2009, Alabama Statutes, and the related SAMC Privacy and Security policies and procedures ("P&P's) (on Southeast Health Intranet) place certain restrictions on the processing, use, and disclosure of individuals' and patients' Protect Health Information ("PHI") and other Confidential Information.

During the performance of duties, colleagues (employees), students, volunteers, and certain contract staff may have access to and/or be involved in the processing of Confidential Information, including but not limited to: patient PHI and electronic PHI ("ePHI") to include medical records; indexes of medical information; patient demographics, billing, and appointment history; confidential communications for diagnosis and treatment purposes; Human Resources ("HR") records; and other business, financial, corporate and proprietary information. Southeast Health expects that all individuals who have been granted authorized access to Confidential Information will do so in a manner consistent with regulatory requirements, laws, and established Southeast Health P&P's related to the transmission, use, and disclosure of Confidential Information and security of Southeast Health information systems and data.

I understand and agree to adhere to the following:

1. All information related to a patient's past, present, or future healthcare and treatment in any facility, department, or unit of Southeast Health is considered "protected health information" (PHI). This information can only be accessed and shared with those who have a "need to know" while performing duties related to treatment, payment, and healthcare operations ("TPO"). While performing my duties, I may have access to information concerning all Southeast Health patients; however, only the minimal amount of information necessary to adequately perform my specific job responsibilities will be accessed.
2. No information concerning Southeast Health patients will be used, disclosed, or discussed outside of Southeast Health unless specifically authorized by the patient, permitted by the HIPAA Privacy Rule, or required by law. If I have any questions about the appropriateness of disclosure, prior to disclosure, I will make inquiry to the appropriate supervisor or the HIPAA Privacy Officer.
3. Patient Information will not be discussed openly in a public environment, such as elevators, corridors, hallways, cafeterias, or at any other location where others may over hear comments. Discussions necessary for the care of the patient will be conducted as discreetly as possible.
4. Only authorized personnel may release copies of the patient's medical record and only in accordance with Southeast Health policy and consistent with state and federal regulations. Patient information, such as name, date of birth, address, and/or social security number, will not

be recorded on any documents which are removed from my work area or from the facility. Patient information may not be photocopied for personal or school-related use.

5. Telephone inquiries concerning a patient's condition must be referred to individuals who are authorized to respond to such inquiries. Disclosure of PHI over the telephone will be done in a manner that reasonably ensures protection of the information, to the greatest extent practicable, without interfering with the intended purpose of the communication.
6. Unless subpoenaed or court ordered to do so, I shall not assist any attorney, plaintiff or prospective plaintiff nor provide testimony against Southeast Health, regardless of whether such testimony is paid or voluntary, relative to litigation in which Southeast Health is or may become involved.
7. I will be the sole user of my user identification code (user ID) and password in connection with my authorized access to information. I will take all necessary steps to prevent anyone from gaining knowledge or use of my password. I understand that my password is recognized as my personal signature on each computer function.
8. Computer passwords will be kept confidential. Inappropriate use of or failure to maintain the confidentiality of any computer password will be cause for disciplinary action.
9. I am responsible and accountable for all entries made and all records retrieved under my username and password.
10. Under no circumstances will I utilize Southeast Health information or communication resources for personal financial benefit or gain; to solicit or distribute personal goods or services; or, for any other purpose harmful to Southeast Health. I understand that inappropriate (non-business) use of these resources that negatively impact my performance may result in disciplinary action.
11. I acknowledge that e-mail communications, computer systems, and any other information resources are not private and may be monitored by Southeast Health to ensure that there is no unauthorized use of the company's systems. I also acknowledge that use of Southeast Health information and communications resources for illegal purposes or in violation of the law; or, to convey offensive harassing, vulgar, or threatening information, including disparagement of others based on race, national origin, marital status, sex, sexual orientation, age, disability, pregnancy, religious or political beliefs, or any other characteristic protected under federal, state or local law, is strictly prohibited and can result in termination.
12. I will respect laws regarding copyrighted software and not make unauthorized copies of software, even when the software is not physically protected against copying.
13. I acknowledge that my obligations and responsibilities continue after termination of employment, contract or affiliation with Southeast Health.
14. I will ensure that Anti-Virus software is installed or removed only by authorized Information Systems ("IS") department staff on any Southeast Health computer or information system. I understand that I am not authorized to bypass this step.
15. I will sign off and/or physically secure a terminal or computer when leaving it unattended in an area open to unauthorized individuals.

16. I will not load copyrighted software, shareware, and/or freeware (software programs that are not protected by copyright) on any IS computer without prior approval by the IS department.
17. I will protect terminals, network devices and personal computers from theft and physical damage.
18. If it is my responsibility to correct colleagues' time in the time and attendance system, I must follow hospital policies set forth in the Southeast Health HR P&P's (on Southeast Health Intranet). I understand that failure to pay colleagues in accordance with hospital policy and procedure can and will result in disciplinary action up to and including termination.
19. I will follow the process established for patients to access patient records and accounts, and I will not access patient records or accounts for myself or family.
20. I will protect from loss or theft any Southeast Health mobile device, to include laptops, PDAs, or storage medium, (such as, CDs, thumb drives, USB sticks) assigned to me or in my possession. Should such a loss or theft occur, I will immediately report it to the Southeast Health IS Help Desk at 793-8088 and to Southeast Health Security.
21. I will report any violation of the Southeast Health HIPAA/Information Security or Southeast Health HIPAA Privacy P&P's to my supervisor or the Southeast Health Privacy Officer.
22. I understand that violations of security and/or privacy rules and P&P's, whether due to carelessness or malicious intent, are causes for appropriate corrective action in accordance with HR P&P's, up to and including discharge.
23. I understand this agreement will not expire.

- All Southeast Health colleagues' access is subject to be renewed at their annual review to re-enforce Southeast Health's HIPAA Privacy and Security P&P's (on Southeast Health intranet).
- All Non-Southeast Health employees must review and sign this Confidentiality Agreement prior to acquiring Southeast Health system access and annually thereafter or at the beginning of a new engagement and/or contract when a break in continuous service is greater than two months, or as determined by the appropriate manager.

24. I acknowledge my access privileges are subject to periodic review, revision, renewal, or revocation and that I am obligated to maintain the confidentiality of any additional information or systems I am granted access to in order to perform my specific job responsibilities.

Student Name	Date
Student Signature	
School Affiliation	

Southeast HEALTH

Applicant Name:_____ Supervising Preceptor: _____

SCOPE OF PRACTICE: MEDICAL STUDENT, PA and/or NP

MINIMAL CRITERIA: Resume; photo for identification purposes; malpractice insurance verifying scope of practice; current BCLS/ACLS certificate; verification of training by medical school director; contract with institution.

PLEASE NOTE: Student

- Must identify him/herself as a medical student under the supervision of the supervising physician;
- May relay verbal or written orders as directed by the supervising physician (SP) with the order being confirmed by the supervising physician and co-signed within 24 hours;
  - Cannot work unless the responsible physician (SP) is in reasonable proximity (within the hospital);
  - All duties requested cannot be performed without permission of the patient;
  - Students shall not administer or prescribe medications, or perform invasive, surgical, diagnostic or other technical procedures, except under the direct supervision of the supervising physician;
  - Student is to be free of significant communicable disease during the rotation, and must provide evidence of TB and hepatitis B screenings;
  - Students may visit, interview and examine assigned patients without the presence of the supervising physician, except where specifically prohibited by Alabama law, i.e, gynecological exams. However, the student may not round on patients in lieu of the supervising physician's rounding.

GENERAL DUTIES

- Elicit histories and perform physical examinations;
- Review patient records for the purpose of developing comprehensive medical status reports;
- Develop treatment plan to be countersigned by supervising physician (SP);
- Perform hospital rounds and record patient progress notes to be countersigned by the supervising physician (SP);
- Relay specific orders at the direction of the supervising physician (SP) to be confirmed by the SP and co-signed by the SP or his/her delegated SP within 24 hours;
- Compile narrative and case summaries, complete forms pertinent to patients' medical records.

SPECIFIC DUTIES: The following duties should be performed under the direct (defined as in the presence of) supervision of the supervising physician:

- Provide instructions and guidance regarding medical care matters to patients;
- Perform or assist in the following laboratory, medical techniques and therapeutic procedures:
- Injections and intravenous therapy
- Rescue measures
- Draw arterial, venous or peripheral blood
- Urinary bladder catheterization
- Nasogastric intubation and gastric lavage
- Collection and gross examination of stool
- Collection of materials for bacteriological/viral cultures
- Suture superficial wounds
- Removal of sutures
- Administration of subcutaneous local anesthesia
- Removal of cast
- Incision and drainage of superficial skin infections

Southeast HEALTH

Student Name: _____

Operating Room Assistant Duties should be performed under the direct (defined as in the presence) supervision of the supervising physician and should have verification of training in sterile technique, proper scrub, gowning, and gloving:

- Scrubbing and assisting by handling tissue, retracting tissue to expose the operative field, using instruments, suturing and knot-tying, and providing hemostasis.

NOTE: All subsequent requests for additional duties must be made in writing to the Credentials Committee within a time frame adequate for approval prior to performance of the procedures. Maintenance of approved duties is subject to ongoing quality assessment monitoring, upon recommendation by the department manager in the primary area of duties.

APPLICATION MUST BE SIGNED AND DATED BY THE SUPERVISING PHYSICIAN AND ALL PHYSICIANS AGREEING TO SUPERVISE THE ABOVE-NAMED STUDENT.

_____ _____
Applicant's Signature Date

By signing below, I agree to provide ongoing periodic reports to the Credentials Committee, Medical Executive Committee and Houston County Health Care Authority regarding the quality of care, treatment and services provided by, and the related educational and supervisory needs of the student.

_____ _____
Primary Supervising Preceptors Signature Date

Southeast HEALTH

Student Name: _____

STATEMENT OF CONFIDENTIALITY

Due to the nature of medical practice, you will be exposed to privileged information concerning patients and their treatment.

Information about a patient is confidential. The hospital organization and its individual employees are both charged with the obligation to safeguard the confidential information regarding patients as well as hospital to include any confidential records and reports.

No patient is to be discussed with another patient.

Patient care should not be discussed in areas where it can be overheard and misinterpreted as gossip, i.e. hallways, elevators, cafeteria. Patients, their care and treatment and any other information obtained should never be discussed outside the hospital.

Patients' Right to Confidentiality

The patient has the right, within the law, to personal and informational privacy, as manifested by the right to:

1. Refuse to talk or see anyone not officially connected with the hospital, or persons officially connected to the hospital but who are not directly involved in his/her care.

2. Expect that any discussion or consultation involving his/her care will be conducted discreetly, and that individuals not directly involved in his/her care will not be present without his/her permission.

3. Have his/her medical record read only be individuals directly involved in his/her treatment, or the monitoring of its quality, and by other individuals only with his/her permission or that of his/her legally authorized representative.

4. Expect all communications and other records pertaining to his/her care, including the source of payment for treatment, to be treated as confidential.

I understand that my breech of the agreements contained herein, or my unauthorized disclosure of any confidential information could result in the termination of my activities as approved by the Hospital or civil action.

Your signature indicates agreement to adhere to the above statements:

_____ _____

Date Signature