



### Medical Student Agreement

My signature below indicates and supports the following:

1. I am a student in good standing in the Medical School Student Program.
2. I hereby agree to function in accordance with all St. Francis Hospital policies and procedures and Medical Staff Bylaws, Rules and Regulations.
3. I hereby acknowledge that I am responsible to a designated supervising physician and I am to function within the attached guidelines.
4. While on duty in the Hospital, I will wear a prominently displayed name tag identifying myself as a Medical Student.

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Medical Student Signature

Date

I acknowledge the above and by my signature indicate responsibility for the acts of the Medical Student identified herein.

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Physician Signature

Date



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## Medical Student Program

\_\_\_\_\_  
Name                      Last                      First                      Middle

\_\_\_\_\_  
Address

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date of Graduation

\_\_\_\_\_  
Institution

\_\_\_\_\_  
**\* Liability Insurance Carrier**

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Amount of Insurance

Assignment Period

\_\_\_\_\_  
From

\_\_\_\_\_  
To

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**\*Attach current policy**

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## CONFIDENTIALITY STATEMENT

I have been asked by St. Francis Hospital, Inc. to affirm my commitment to protect the confidentiality of health information and hospital records retained in any medium; written, electronic, and orally. I understand that St. Francis Hospital, Inc. reminds its associates and volunteers of their confidentiality obligations on a periodic basis to help ensure compliance, due to the significance of this issue. By my signature below, I acknowledge that I am making the commitment set forth below at the time of my employment.

St. Francis Hospital, Inc. has a legal and ethical responsibility to safeguard the privacy of all patients and protect the confidentiality of their health information. In the course of my employment at St. Francis Hospital, Inc., I may come into possession of confidential patient information, even though I may not be directly involved in providing patient services.

I understand that such information must be maintained in the strictest confidence. As a condition of my employment, I hereby agree that, unless directed by my supervisor, I will not at any time during or after my employment with St. Francis Hospital, Inc. disclose any patient information to any person whatsoever or permit any person whatsoever to examine or make copies of any patient reports or other documents prepared by me, coming into my possession, or under my control, or use patient information, other than as necessary in the course of my employment/assignment.

When patient information must be discussed with other health care practitioners in the course of my work, I will use discretion to ensure that others who are not involved in the patient's care cannot overhear such conversations.

I understand that violation of this agreement may result in corrective action, up to and including discharge.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date



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# ***POLICY AND PROCEDURE***

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**POLICY NUMBER:**

**PAGE 1 OF 5**

**POLICY TITLE: Non Employees Providing Care, Treatment, and Services**

**EFFECTIVE DATE: February 6, 2009**

**REV. DATE:**

**APPROVED BY:**

***Signature on file***  
Vice President

***Signature on file***  
President

## **STATEMENT OF POLICY:**

At St. Francis Hospital we have many non employees who contribute to our care, treatment and service for our patients. For safety and security of our patients, we have requirements for our non employees based on their role in the organization. When those requirements are met the non employee will be issued a security ID. The non employee will not be able to provide care and treatment until a security identification is issued.

## **SCOPE:**

This policy applies to all non-employees who provide care, treatment or services at St. Francis Hospital, Inc.

## **RESPONSIBILITY:**

Each **Division** will be responsible for compliance of this policy. Areas of responsibility include:

It is the responsibility to **Human Resources Recruitment** to ensure compliance with this policy for **clinical non-employees** other than those working under the supervision of a licensed independent practitioner.

It is the responsibility of **Medical Staff Services** to ensure compliance with this policy for **non-employees working under the supervision of a licensed independent practitioner.**

It is the responsibility of **Materials Management** to ensure compliance with this policy for **vendors and service workers.**

It is the responsibility of **Education** to ensure compliance with this policy for **students, unpaid interns, and job shadowing individuals.**

It is the responsibility of **Volunteer Services** to ensure compliance with this policy for **volunteers**.

It is the responsibility of **Facility Services** to ensure compliance with this policy for **contractors** providing maintenance and repair services.

**PROCEDURE:**

1. The non-employee completes an information form.
2. Identify the appropriate category of the non-employee:

Categories of Non Employees Providing Care, Treatment, or Services

Category 1	Non employees with access to public areas only with no clinical role.
Category 2	Non employees with access to public areas and private offices with no clinical roles and no patient contact.
Category 3	Non employees with access to high risk security areas and with some patient contact but no direct patient care
Category 4	Non employees with access to high risk security areas, with patient contact and direct patient care.

The list of non employees providing care, treatment or services include but are not limited to students, volunteers, clinical contractors, facility contractors, forensic staff, vendors, staff working for Licensed Independent Practitioners that provide care, treatment or services within our organization, consultants, high school apprentices and researchers. Each individual must complete an information form to determine the assigned category and then complete the required steps to gain access to the facility.

3. Once the category has been identified, complete the required elements as indicated on the chart on page 4 of this policy. A non employee may provide manual documentation of all required elements or provide access to a credentialing verification organization approved by St. Francis Hospital.



**REQUIRED ELEMENTS FOR NON EMPLOYEES PROVIDING CARE, TREATMENT AND SERVICES**

	<b>CATEGORY 1</b>	<b>RESPONSIBLE PARTY</b>	<b>CATEGORY 2</b>	<b>RESPONSIBLE PARTY</b>
<b>SCREENING</b>				
Criminal Background Checks (National)	N/A	N/A	N/A	N/A
TB Screening	N/A	N/A	N/A	N/A
Flu Vaccine or rationale for no vaccine	N/A	N/A	N/A	N/A
Hep B vaccine received or declined	N/A	N/A	N/A	N/A
MMR	N/A	N/A	N/A	N/A
Varicella	N/A	N/A	N/A	N/A
<b>ORIENTATION PACKET</b>				
Safety	X	Assigned Department	X	Assigned Department
Infection Control	X	Assigned Department	X	Assigned Department
OR Protocol	N/A	N/A	N/A	N/A
HIPPA	X	Assigned Department	X	Assigned Department
Behavioral Code of Conduct	X	Assigned Department	X	Assigned Department
<b>JOB DESCRIPTION -</b>	N/A	N/A	N/A	N/A
<b>INITIAL ASSESSMENT OF COMPETENCIES -</b>	N/A	N/A	N/A	N/A
<b>CURRENT PERFORMANCE EVALUATION</b>	N/A	N/A	N/A	N/A
<b>SECURITY -</b>				
Check in at.....	X	Assigned Department	X	Assigned Department
Hospital ID tag....	X	Assigned Department	X	Assigned Department

**REQUIRED ELEMENTS FOR NON EMPLOYEES PROVIDING CARE, TREATMENT AND SERVICES**

	<b>CATEGORY 3</b>	<b>RESPONSIBLE PARTY</b>	<b>CATEGORY 4</b>	<b>RESPONSIBLE PARTY</b>
<b>SCREENING</b>				
Criminal Background Checks (National)	X	Division	X	Division
TB Screening	X	Division	X	Division
Flu Vaccine or rationale for no vaccine	X	Division	X	Division
Hep B vaccine received or declined	X	Division	X	Division
MMR	X	Division	X	Division
Varicella	X	Division	X	Division
<b>ORIENTATION PACKET</b>		Division		Division
Safety	X	Division	X	Division
Infection Control	X	Division	X	Division
OR Protocol	If OP Invasive Access	Assigned Department	If OP Invasive Access	Assigned Department
HIPPA	X	Division	X	Division
Behavioral Code of Conduct	X	Division	X	Division
<b>JOB DESCRIPTION -</b>	X	Assigned Department	X	Assigned Department
<b>INITIAL ASSESSMENT OF COMPETENCIES -</b>	X	Assigned Department	X	Assigned Department
<b>PERFORMANCE EVALUATION AT 90 DAYS</b>	X	Assigned Department	X	Assigned Department
<b>SECURITY -</b>				
Check in at.....	X	Assigned Department	X	Assigned Department
Hospital ID tag....	X	Assigned Department	X	Assigned Department

**ST. FRANCIS HOSPITAL  
REQUEST FOR CLINICAL OBSERVATION  
And  
RELEASE OF RESPONSIBILITY/LIABILITY**

This Observer Request form is to be filled out and turned in to the area Department Director or Medical Staff Services Office at least 1 week prior to the anticipated date of Clinical Observation.

**It is expressly understood that all clinical observers are restricted to observation only and at no time are permitted to participate in the hands-on care of any patient.**

**SECTION I**

(to be filled out by the Hospital Employee or Member of the Medical Staff requesting permission for a clinical observer)

Name of Person requesting permission for an observer: \_\_\_\_\_  
Contact Phone Number: \_\_\_\_\_  
Date that Observer will be on site: \_\_\_\_\_  
Name of Observer: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_  
Address of Observer: \_\_\_\_\_  
Clinical Background of Observer: (experience, licensure, certification, etc.) \_\_\_\_\_  
(please attach copies of licensure, certification, or other documentation) \_\_\_\_\_  
School affiliation (if any): \_\_\_\_\_  
Purpose of Observation: (provide sufficient details to permit proper assessment of request) \_\_\_\_\_

Location Where Observer will be on campus of hospital: \_\_\_\_\_  
Select One only: \_\_\_\_\_ Observer will observe one patient/case/procedure only  
\_\_\_\_\_ Observer will observe some or all of my patients/cases/procedures for this date.

If observation is for one patient, case, or procedure only, indicate name of patient: \_\_\_\_\_

I, the undersigned sponsor of the above named request for a clinical observer, fully understand that it is my responsibility to obtain permission from each of my patients, and or any patients we encounter for this observer to be present during any part of my interaction with said patients. I also understand that it is my responsibility to document that I obtained this permission in the patient's medical record.

Additionally, I accept full responsibility for any and all actions of the observer while s/he is here accompanying me on the campus of St. Francis Hospital.

Signature of Person Requesting an Observer and Observer: \_\_\_\_\_  
Date Signed: \_\_\_\_\_

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**SECTION II**

(to be completed by Department Director or Medical Staff Services Office)

1. Request Reviewed and Approved: \_\_\_\_\_ Request Denied: \_\_\_\_\_  
Reason for Denial of Request: \_\_\_\_\_  
Denial communicated to: \_\_\_\_\_ on: \_\_\_\_\_ by: \_\_\_\_\_
2. 2 Copies of Observer Protocol provided to Sponsor , one for sponsor and one for observer. \_\_\_\_\_
3. All appropriate Hospital Personnel notified of approved requests for observation, including name, date, and purpose of observation. \_\_\_\_\_

Department Director / Chief Medical Officer: \_\_\_\_\_  
Signature Date