CATHOLIC HEALTH INITIATIVES

Franciscan Medical Group

A Part of Franciscan Health System

Application for Student Rotation at FMG

Student Placement Packet

Check type of Student			
☐ **MEDICAL STUDENT**	☐ **NURSE PRACTITIONER STUDENT**	☐ **PHYSICIAN ASSISTANT STUDENT**	☐ **OTHER:** (i.e. Residency, Fellowship, Observership) _____

Check type of Student Placement			
☐ **CLINICAL ROTATIONS**	☐ **INTERNSHIP**	☐ **JOB SHADOW**	☐ **RESIDENT OR FELLOW**
Last Name:	First Name:	Middle Initial:	Date of Birth:
E-mail Address:		Phone Number:	☐ Male ☐ Female
WA State Medical License # (If applicable):		Expiration date:	University/College:
School / University Coordinator's Name:		School / University Coordinator's E-mail or Phone No.:	

Schedules of Rotations/Other:	**Autumn Quarter** (circle days of rotations) M T W TH F S SU Start Date: ___/___/___ End Date: ___/___/___	**Winter Quarter** (circle days of rotations) M T W TH F S SU Start Date: ___/___/___ End Date: ___/___/___	**Spring Quarter** (circle days of rotations) M T W TH F S SU Start Date: ___/___/___ End Date: ___/___/___	**Summer Quarter** (circle days of rotations) M T W TH F S SU Start Date: ___/___/___ End Date: ___/___/___

BRIEF DESCRIPTION OF STUDENT PARTICIPATION:

REQUIRED DOCUMENTS must be received two (2) weeks prior to the start of your rotation

- Completion of this Student Placement Packet (3 page form)
- CV or an outline of education and experience
- TST Skin Testing information * current within one year (see attached guidelines)
- Current Immunization Record (Hep B, MMR, Varicella, Tetanus/Diptheria, TST, Influenza)
- Copy of a government issued photograph ID (copy driver's license or passport * SCAN works best)
- Signed "Scope of practice" and "Letter of Agreement" (it is the students' responsible in obtaining the sponsor signature with whom they will be rotating)
- School/university must provide: Student background check, Professional Liability Insurance, and any Completed license(s).
- **IF YOU HAVE BEEN CONVICTED OF A MISDEMEANOR OR FELONY, PLEASE PROVIDE FULL DETAILS OF THE INCIDENT AND CIRCUMSTANCES.**

PLEASE NOTE:

All required documents should be submitted to Kris Bozeman LPN, Sr. Clinical Trainer. Please scan or fax documents to:

E-mail Address: KristinBozeman@fhshealth.org **or Fax:** (253) 552-4185

ANY FURTHER QUESTIONS and/or CONCERNS PLEASE CONTACT KRIS BOZEMAN at office number: (253) 552-4129

Mailing Address:
Franciscan Medical Group – Service Center
1149 Market Street • Tacoma, WA 98402
Quality & Risk Management Department
Mail-Stop: 10–14

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This form must be completed for EACH ROTATION at FMG Clinic(s).

The following are the general guidelines and requirements for bringing a student into a clinic or hospital for the observation of patient or in-hospital patient care activities.

SCOPE OF PRACTICE

- Direct supervision by the sponsor or designee shall be maintained at all times. Direct supervision is defined as physically present.
- Preceptor/Sponsor shall ultimately be responsible for the care of the patient.
- Student may accompany the preceptor/sponsor on all in-house patient care activities, but shall have no direct patient responsibilities. The patient must be informed of the students' status. Only after a patient consents, the student may participate in minor procedures for which the preceptor/sponsor is credentialed and may assist only under the direct supervision of the preceptor/sponsor. A student's participation is expected to be minor, such as changing dressings.
- Student may write progress notes with co-signature by preceptor/sponsor. Progress notes shall be signed, dated and timed by student. Progress notes shall also be signed, dated and timed by the preceptor/sponsor.
- Participate in procedures for which the preceptor/sponsor is credentialed, to scrub, assist with retraction, suctioning, suturing and cutting sutures during operative procedures under the direct supervision of the preceptor/sponsor.
- Job Shadow participation is limited to **observation only** and is at the discretion of the assigned preceptor/sponsor.
- Job Shadow participants are limited to 1-2 days experience only and are not authorized to do any tasks (patient care, or incidentals). Violation of this policy is grounds for immediate dismissal.

LETTER OF AGREEMENT

- Student must be enrolled in good standing at their respective University/College. Physician/Advanced Practice Provider (APP) Sponsor must provide FMG & FHS with evidence of such good standing.
- There shall be an education affiliation agreement between the University/College and Franciscan Medical Group.
- Student is covered by adequate medical malpractice insurance of at least $1,000,000 per occurrence and $3,000,000 aggregate coverage, and covered by adequate health insurance. Student shall provide documentation of adequate medical malpractice insurance coverage.
- Student will participate in a two to four or six to eight week rotation/preceptorship rotation depending on student's curriculum.
- Student agrees to have his/her school or FMG clinic sponsor to do a criminal background check (i.e. WA State Patrol et al).
- The patient must be informed of the students' status. Only after a patient consents, the student may participate in minor procedures for which the sponsor is credentialed and may assist ***only under the direct supervision of the preceptor/sponsor***; participation as outlined above.
- Student must wear a name-badge identifying him/her as a student.
- Student must forward all the required documents to the FMG Quality & Risk Management Department, Attn: Kris Bozeman, for review at least two weeks prior to start of their rotation/preceptorship and will be notified when approved.
- Prior to arrival of the student, the preceptor/sponsor will notify the clinic manager and department about the presence of the medical student, the dates when he/she will be at the facility and the type of student placement/program.
- Preceptor/Sponsor must be clearly identified; and must agree to accept full responsibility for direct supervision at all times.
- Preceptor/Sponsor shall introduce the student to the patient and assure appropriate consent is obtained for observation and/or participation.

DATES of clinical rotations/other:	**CLINIC where you will do rotations:**	**Name of your Preceptor / Sponsor:**
FR:_____THRU_____	_____	_____

My signature below indicates that I acknowledge these guidelines/scope of practice and agree to be bound by the requirements as outlined above.

_____ _____

Student Signature Date

_____ _____

PRINT STUDENT NAME **SCHOOL / UNIVERSITY NAME**

****NOTE: MUST BE SIGNED BY PROVIDER WHO IS SPONSORING/PRECEPTING YOU****

My signature below indicates that I acknowledge

- **these guidelines and agree to be bound by the requirements as outlined above**
- **the student "scope of practice" outlined above**
- **In addition, my signature below indicates that I assume sole responsibility and liability for the actions of the student.**

_____ _____

Preceptor/Sponsor Signature Date

_____

PRINT PRECEPTOR / SPONSOR NAME

Noted by:

_____ _____

Clinic Manager Signature Date

_____

PRINT CLINIC MANAGER NAME

CONFIDENTIALITY AGREEMENT

I understand that Franciscan Medical Group (FMG) considers it the ethical responsibility of each employee, contracted employee, student or volunteer to respect and maintain the confidentiality of patients, physicians and fellow staff members, as well as organizational information. Therefore, it is expected that I will be worthy of the trust given me and that I will perform my duties to the best of my ability with intelligence, courtesy, tact, and cheerfulness.

I acknowledge that access to confidential information is for the purpose of performing my responsibilities within this organization and for no other purpose. I understand that confidential information is protected in every form, such as written records and correspondence, oral communications, and computer programs and applications. Medical records are legal documents and contain confidential information. Staff must use extraordinary caution when handling records. Unauthorized disclosure of medical record information could result in legal action against the hospital and against the employee or volunteer who violates the patient's rights.

I understand that all information regarding patients and their health care is strictly confidential. Information of a privileged nature is to be shared only with authorized parties and such discussions should be held in a private location.

I understand that information of a personal nature regarding fellow co-workers is also considered confidential. Employees' addresses, home phone numbers, work schedules, and any other personal information shall not be released to a third party without the express permission of the employee involved. All requests for employment verification or job references must be referred to the FMG Human Resources Department.

I understand and agree that in the performance of my duties as an employee, contracted employee, student or volunteer Franciscan Medical Group, that I must hold patient, physician, employee and organizational information in confidence. I understand that any violation of the confidentiality policy may result in corrective action, including termination. I agree that my obligations under this agreement continue after my employment ends.

Print Name (including middle initial)	Signature
FMG Clinic / Facility Name	Date(s) in Clinic
Noted by: Preceptor / Sponsor Name	Preceptor / Sponsor Signature