CABELL HUNTINGTON HOSPITAL
1340 Hal Greer Boulevard, Huntington, WV 25701

APPLICATION FOR CLINICAL ROTATION

Name: _____ SS No.:_____

Address: _____

_____

Supervising Physician: _____

I, _____, agree to be the supervising physician for
(supervising physician's name)

_____. He/she is a _____
(applicant's name) (applicant's level of training)

from _____ who will be working with me from
(name of educational institution)

_____ to _____ at Cabell Huntington Hospital, Inc.
(date) (date)

I accept all responsibility for the actions of this applicant while he/she is acting under my direction. He/she will be permitted to perform those activities described in Attachment A in accordance with the policies and procedures, bylaws, rules and regulations of Cabell Huntington Hospital, Inc., and its Medical and Dental Staff.

_____ _____
Signature of Supervising Physician Date

_____ _____
Signature of Applicant Date

REQUIRED ATTACHMENTS:
1. Proof of insurance for applicants.
2. Confidentiality Agreement for Volunteers and Students signed by applicant.
3. Non-Employee Attestation Form and Signature page
4. Letter of confirmation from teaching institution establishing that applicant is a student in good standing and that this clinical experience is an approved elective within the educational program of the teaching institution.
5. Attachment A describing level of activities.

APPROVED:

_____ _____
Vice President of Medical Affairs Date

CABELL HUNTINGTON HOSPITAL
1340 Hal Greer Boulevard, Huntington, WV 25701

ATTACHMENT A

Applicant:_____

Supervising
Physician:_____

The above named applicant shall be permitted to do the following in accordance with the policies and procedures, bylaws, rules and regulations of Cabell Huntington Hospital, Inc., and its Medical and Dental Staff:

☐ Make rounds with the supervising physician for the purpose of observation.

☐ Perform History & Physicals which are to be considered only of educational value to the applicant and are not to be considered a part of the patient's official medical record.

☐ Observe in the Operating Room/Delivery Room accompanied by the supervising physician.

☐ Scrub/assist under the direct supervision of the supervising physician in the Operating Room/Delivery Room.

☐ Additional privileges (outline, in full, privileges requested while in the confines of the hospital):

_____

_____

_____

_____ _____
Signature of Applicant Date

_____ _____
Signature of Supervising Physician Date

Non-Employee Attestation Form and Signature Page
(Completion of this document is required before an ID badge will be issued)

Name: DOB: Date:

Primary Source Verification I attest that I hold a valid WV license, certification or registration as required for the services I will be performing if required by law or regulation. I further attest that a copy of primary source verification can be provided before I initially begin performing services at Cabell Huntington Hospital and primary Source Verification is available before my license, certification or registration expires.	initial
Orientation and Confidentiality Agreement I attest that I have read and understand orientation materials and that my duties and responsibilities to maintain confidentiality as set forth in the Cabell Huntington Hospital Confidentiality Agreement shall remain in effect even after my access to PHI ceases	Initial
Criminal Background Check I attest that I have completed a background check and passed within the last 12 months.	
Drug Test I attest that I have taken and passed a 10 panel drug test within the last 12 months.	Initial
Hepatitis B Vaccination ☐ I attest that I have had the Hepatitis B vaccination. ☐ I attest that I have declined the Hepatitis B vaccination. If I have not had the vaccine, I understand that I may take the vaccine at any time.	Initial
Influenza Vaccination I attest that I ☐ have ☐ have not received the influenza vaccination during the most recent influenza season (October to March). If I have not had the vaccine, I understand that I may take the vaccine at any time during the influenza season and I must completed a declination form.	Initial
MMR Vaccination Record I attest that I have had the MMR vaccination and or have been deemed immune.	Initial
Varicella Vaccination Record, ☐ I attest that I have either had the chicken pox during my life or that I have had the Varivax vaccination. ☐ I understand that if I have not had the disease or have not been deemed immune a vaccine is available and that I may take the vaccine at any time.	Initial
Tdap Vaccination Recommended I attest that I ☐ have ☐ have not taken the Tdap vaccine. I understand that if I have not had the disease a vaccine is available and that I may take the vaccine at any time.	Initial
TB Skin Test I attest that I have had a negative TB skin test in the last 12 months Date of test:_____ Who Has a Copy of your TB test results? Name:_____ Phone / Fax	Initial
Physical and Functional Status I attest that I have no physical or mental disabilities that would prevent me from performing services at Cabell Huntington Hospital.	Initial
Color Blind I attest that I ☐ am ☐ am not color blind. If I am color blind I attest that I will not perform activities while at Cabell Huntington Hospital that requires color comprehension	Initial
FIT Test I understand that in order to go into a room where a patient is on airborne precautions I must wear a special N95 respirator mask. I attest that I will not enter that area unless I have been fit tested at Cabell Huntington Hospital.	initial

Release of Information. I authorize the use or disclosure of any health information listed on this page to Cabell Huntington Hospital. I understand that authorizing the use or disclosure of this health information is voluntary but may be a condition being able to perform services or otherwise conduct business with Cabell Huntington Hospital. Unless revoked, this authorization will be effective for no more than two years from the date signed.

Written Name Signature Date

I attest that I have given correct information on this attestation form. I understand that if asked can provide verification of this information. I understand that providing false information will result in me no longer being able to perform services or otherwise conduct business with Cabell Huntington Hospital.

Written Name Signature Date

Department Manager Signature Date

Cabell Huntington Hospital

CONFIDENTIALITY AGREEMENT FOR VOLUNTEERS, STUDENTS, OBSERVERS, OUTSIDE CONTRACTORS AND OTHER NON-EMPLOYEES

Welcome to Cabell Huntington Hospital, Inc. ("the Hospital"). While at the Hospital or at any facilities owned or operated by the Hospital, you may have access to protected health information ("PHI") for treatment, payment or healthcare operation purposes as those terms are defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") as well as confidential and proprietary information about the Hospital and its business transactions and relationships. This information is confidential, and it shall not be disclosed to anybody inside or outside of the Hospital except to those people who are authorized by law or hospital policy to receive such information. See, for example, Administrative Policy II-5 "Release of Protected Health Information." You may not discuss this information with family or friends even if the information is about them. Patients expect the Hospital to keep their medical information confidential and you are expected to respect their rights and abide by applicable laws and hospital policies.

By signing this Confidentiality Agreement, I hereby agree to the following terms and conditions:

1. I shall keep confidential all PHI, regardless of whether it is oral, written or maintained in electronic media, and I shall use or disclose such PHI only as permitted by HIPAA or other applicable federal, state or local laws, rules or regulations. I shall also keep confidential all confidential and proprietary information about the Hospital and its business transactions and relationships.

2. I understand that my access to PHI at the Hospital shall be monitored, and I shall be held responsible for all attempts at access using my password regardless of who is actually attempting such access. Therefore, I shall safeguard my password at all times and not share it with any other individuals for any purpose or reason. Likewise, I shall not use another person's password to access PHI. I also shall log off of any Hospital system that contains or provides access to PHI as soon as I am finished using such system, in order to prevent unauthorized access. I shall not photograph, print or otherwise copy PHI, including copying PHI to electronic storage media, unless specifically authorized to do so by my supervisor or preceptor or pursuant to my agreement with the Hospital.

3. I understand that I may have access to PHI beyond what I need to carry out my specific duties and responsibilities. I acknowledge that the fact that I may have access to such PHI does not authorize me to access such PHI in the absence of a legitimate reason to do so. Therefore, I shall limit access to PHI to what is specifically necessary to carry out my specific duties and responsibilities as a student, volunteer, observer, outside contractor or other non-employee.

4. I understand that access to PHI of Hospital employees, friends and family members is subject to the same use and disclosure requirements as access to any other patient's PHI. Therefore, I shall not access PHI of Hospital employees, friends or family members beyond what is specifically necessary to carry out my duties and responsibilities.

5. I understand that posting PHI or other confidential or proprietary information from the Hospital on social media is never permitted and that removal of patient names is not sufficient to satisfy HIPAA requirements for use and disclosure of PHI.

6. I shall report any of the following to the Hospital's Privacy Officer immediately at (304) 399-2997 or privacyofficer@chhi.org:

    a. If my password is used by another person for access to PHI.
    b. If I become aware of any unauthorized use or disclosure of PHI.
    c. If I ever find that I have accessed PHI in error.

d. If I am advised by a patient or family member of unauthorized use or disclosure of PHI.

7. I understand that information about Hospital employees contained in their personnel and employee health files is also confidential and should be handled as set forth in Administrative Policy V-23 "Confidentiality of Personnel Records"and Administrative Policy V-24 "Confidentiality of Employee Health Records."

8. I also understand that information, such as proprietary information about the Hospital's operations, incident reports, materials designated as "Peer Review" by the Medical and Dental Staff, information concerning lawsuits in which the Hospital is involved, and other similar information shall be treated as confidential and not disclosed to others, such as in a paper or presentation for a class assignment, without the prior permission of my supervisor or preceptor or pursuant to my agreement with the Hospital.

9. I understand that failure to comply with applicable laws and hospital policies and procedures on confidentiality may result in (i) loss of access; (ii) where applicable, termination of my status at the Hospital and/or any agreement the Hospital may have with me and (iii) where applicable, such actions that may be taken by the Office for Civil Rights, U.S. Department of Health and Human Services, in response to a complaint about a violation of HIPAA.

10.. I understand that my duties and responsibilities to maintain the confidentiality of information as described in this Confidentiality Agreement shall remain in effect even after leaving the Hospital.

I have read and understand the information set forth above concerning confidentiality, and I agree to comply with this Confidentiality Agreement as well as all applicable laws and hospital policies and procedures on confidentiality and privacy.

Print Name: _____

Signature: _____Date:_____

Signature of Parent or Guardian if under age 18: _____

Originated:	5/7/13
Reviewed:	
Revised:	

TERMS AND CONDITIONS FOR PARTICIPANTS
CLINICAL ROTATIONS
AT CABELL HUNTINGTON HOSPITAL

The following terms and conditions shall apply to all participants in clinical rotations at Cabell Huntington Hospital ("the Hospital"), unless otherwise modified or amended by a formal affiliation agreement between the Hospital and the educational institution where the participant is enrolled as a student or resident.

1. Definitions - the following definitions shall apply in these terms and conditions:

    a. **Practitioner** - a physician, dentist, nurse or other health care provider who is responsible for supervising a participant in one of the programs covered by these terms and conditions.
    b. **Clinical Rotation** - an educational opportunity whereby the participant, under the supervision of the sponsoring practitioner, may engage in "hands-on" training. The scope of the "hands-on" training and whether the participant shall document in the patient's medical record shall be specifically established in advance of the clinical rotation.
    c. **Program** - a collective term for clinical rotation.

2. All participants shall provide documentation that they are in good standing with their educational institution and that the educational institution authorizes or has no objection to the participant being in the program.

3. All participants in a clinical rotation shall provide proof of professional liability ("malpractice") insurance which shall specifically provide coverage while they are in the clinical rotation.

4. The Hospital makes no representation that participation in a program at the Hospital will cause any participant to quality for licensure or certification in the field for which they are to receive training.

5. The Hospital reserves the right to remove from the program any participant whose health, conduct or performance is a detriment to patient well-being, to the achievement of the educational objectives of the program, or to the safe and orderly operation of the Hospital.

6. The participant shall agree to abide by the policies, procedures, bylaws, rules and regulations of the Hospital, and, if applicable, of its Medical and Dental Staff, including, without limitation, those policies and procedures related to the following:

    a. corporate compliance & standards of conduct
    b. preventing infection and injury
    c. environment of care and safety
    d. HIPPAA privacy standards
    e. patient safety
    f. service excellence behavioral standards

    The Hospital reserves the right to require specific documentation from the participant concerning compliance with the above-listed policies and procedures.

7. The Hospital shall provide emergency medical care to participants, but participants shall be expected to pay for such care.

8. The Hospital shall provide the same protective devices (gowns, masks, gloves, glasses, etc.) to participants that are provided to employees.

9. The participant shall provide to the Hospital a signed attestation which covers knowledge of pertinent Hospital policies, standards and all required vaccinations. Upon request, the participant shall also provide documentation of compliance with these requirements.

10. Upon request, the participant shall provide to the Hospital evidence of medical screening tests signed by a physician that assures the absence of any communicable disease that would potentially pose a risk to the Hospital's patients, employees or Medical and Dental Staff.

11. The Hospital reserves the right to not assign a participant to a particular care situation if so requested by a patient or patient's physician.