San Diego Nursing Service-Education Consortium

STUDENT ORIENTATION RECORD

Consortium #: _____	Orientation Date: _____ Rotation dates: _____ to _____
Course # : _____ Course Title: _____	College:_____ Level of student: _____
Instructor: Name:_____ ***License #/exp date:*** _____ Email: _____ Work phone: _____ Cell/other: _____	Hospital/Agency:_____ Clinical Area: _____

I verify that the students listed below meet all requirements defined by policy: ***San Diego Nursing Service-Education Consortium Faculty/Student Requirements.***

Director/Faculty signature: _____ Date: _____

A minimum of two weeks prior to the first clinical day, provide this form and the course objectives to the hospital's student coordinator.

Student's Printed Name	Student ID or SS#	*Flu Shot* Y/N/D	*Student Phone #*	Emergency contact/phone

Note: Attach copy of flu vaccine administration or declination form if required by hospital
05/09

EXHIBIT A

STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of Alvarado Hospital ("Hospital"), the undersigned and his/her heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the Program operated by _____ ("School") at Hospital unless such injury or loss arises solely out of Hospital's gross negligence or willful misconduct.

	PRINTED Name	**Signature**	✓	**Date**
1			☐Student ☐Faculty	
2			☐Student ☐Faculty	
3			☐Student ☐Faculty	
4			☐Student ☐Faculty	
5			☐Student ☐Faculty	
6			☐Student ☐Faculty	
7			☐Student ☐Faculty	
8			☐Student ☐Faculty	
9			☐Student ☐Faculty	
10			☐Student ☐Faculty	

Witness:

_____
Print Name

_____
Signature

EXHIBIT B

CONFIDENTIALITY STATEMENT

The undersigned hereby acknowledges his/her responsibility under applicable federal law and the Agreement between by _____ ("School") and Alvarado Hospital ("Hospital"), to keep confidential any information regarding Hospital patients and proprietary information of Hospital. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Hospital, except as required by law or as authorized by Hospital. The undersigned agrees to comply with any patient information privacy policies and procedures of the School and Hospital. The undersigned further acknowledges that he or she has viewed a videotape regarding Hospital's patient information privacy practices in its entirety and has had an opportunity to ask questions regarding Hospital's and School's privacy policies and procedures and privacy practices.

	PRINTED Name	**Signature**	✓	**Date**
1			☐Student ☐Faculty	
2			☐Student ☐Faculty	
3			☐Student ☐Faculty	
4			☐Student ☐Faculty	
5			☐Student ☐Faculty	
6			☐Student ☐Faculty	
7			☐Student ☐Faculty	
8			☐Student ☐Faculty	
9			☐Student ☐Faculty	
10			☐Student ☐Faculty	

Witness:

_____
Print Name

_____
Signature

EXHIBIT C

ATTESTATION OF PROGRAM PARTICIPANT PRE-ASSIGNMENT INFORMATION VERIFICATION

Name of School: _____ **Date:** _____

For all Program Participants listed below, please verify the following information is contained in Program Participants file and that the requirements of this attestation form have been completed in their entirety. Please send this completed attestation form to Alvarado Hospital PRIOR to the Program Participant being sent to the facility. Program Participants will not be permitted to start their onsite assignment without this completed attestation.

		Pre-Assignment Screening Copies of relevant/required certifications				**Health Screening**							**Fit Test**
	PRINTED name	**Picture id type**	**Date healthcare provider CPR card expires**	**(1) Date criminal background conducted**	**Date of 10-pannel drug screen**	**(2) Any physical/health limitations**	**Date of last negative tuberculosis screening (PPD and/or chest x-ray) (within last**	**Date Hepatitis B series completed or declination signed**	**Evidence of Rubella, Rubeola, Mumps, and Varicella immunity**	**Evidence of a physical in last 12 months**	**Date last physical conduced**	**TDAP immunization**	**(3) Date initial/annual fit testing**
1		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
2		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
3		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
4		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
5		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
6		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
7		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
8		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
9		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	
10		☐Driver license ☐Student ID ☐Passport				☐Yes ☐No			☐Yes ☐No	☐Yes ☐No		☐Yes ☐No ☐Declined	

(1) Criminal background check must include Social Security number verification, Criminal Search (7 years), Violent Sexual Offender & Predator registry, HHS OIG/GSA Excluded Parties (2) If yes, please contact Administrative Coordinator (3) This requirement will be completed by Hospital (3M, N95 mask, #1860 and #1860S, regular and small sizes Kimberly-Clark, N95 mask, #46727 and #46827, regular and small sizes)

I **attest** that all of the information contained herein on side one is accurate and acknowledge that Program Participant must complete all requirements prior to participation in the Program. Any falsification of information will result in immediate termination of the Agreement and possible punitive actions as available under applicable law.

PRINTED Name of School Representative Completing: _____

Signature of School Representative Completing: _____ Date: _____

EXHIBIT D

NON-EMPLOYEE HOSPITAL ORIENTATION SELF-LEARNING MODULE (Clinical Staff)

Self-Learning Module Content:

- Abuse Reporting
- Breaks/Lunches
- Body Mechanics
- Chain of Command
- Concerns about Safety, Quality or Ethics
- Core Measures
- Cultural Diversity
- Custody Unit
- Documentation/Nursing Documentation
- Dress Code
- Electrical Safety
- Emergency Codes and Basic Staff Response
- End of Life Issues/Care of the Dying Patient
- Fall Prevention
- Fires
- Forensic Services
- Hazardous Materials
- HIPAA/Patient Confidentiality
- Infection Control/Blood borne Pathogens/Isolation Guidelines
- Life Safety Measures
- Medication Administration/Do Not Use Abbreviations
- Mission/Vision
- National Patient Safety Goals Organ/Tissue Donation
- Pain Management
- Parking Policy
- Patient Rights and Responsibilities
- Performance Improvement
- Patient Satisfaction/Customer Service/Patient Complaints
- Physicians and Other Licensed Independent Practitioners Identification, Recognition/ Reporting of Impairment
- Population Served Issues
- Procedural Sedation
- Rapid Assessment Team
- Restraints
- Safety/Risk Management/Error Reporting
- Smoking Policy
- Stroke Care
- Supply Management
- Team Dynamics
- Verbal/Telephone Order Read Back

	PRINTED Name	Signature	Test Score*	Date
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

*Passing score is 80%

I **c**ertify that the participants listed above have successfully complete the Non-Employee Hospital Orientation Self-Learning Module (Clinical Staff) test.

Faculty:

_____

Print Name

_____

Signature

EXHIBIT E

ACCU-CHEK INFORM® SYSTEM GLUCOSE METER COMPETENCY

	PRINTED Name	**Signature**	**Date**	**Test Score***	**Competency Validated**
1					☐Yes ☐No
2					☐Yes ☐No
3					☐Yes ☐No
4					☐Yes ☐No
5					☐Yes ☐No
6					☐Yes ☐No
7					☐Yes ☐No
8					☐Yes ☐No
9					☐Yes ☐No
10					☐Yes ☐No

*A score of 100% is required

I certify that that participants listed above have successfully complete the AccuChek glucose monitor competency validation and test**.**

Faculty:

_____
Print Name

_____
Signature

EXHIBIT F

MS4 CLINICAL SUITE ELECTRONIC MEDICAL RECORD
NURSING DOCUMENTATION TRAINING ON-LINE COURSE

	PRINTED Name	**Signature**	**Date**	**Certificate of Completion Validated**
1				☐Yes ☐No
2				☐Yes ☐No
3				☐Yes ☐No
4				☐Yes ☐No
5				☐Yes ☐No
6				☐Yes ☐No
7				☐Yes ☐No
8				☐Yes ☐No
9				☐Yes ☐No
10				☐Yes ☐No

I certify that the participants listed above have successfully completed the MS4 Clinical Suite Electronic Medical Record Nursing Documentation Training On-line Course. I have validated that each participant has completed the course by viewing his or her certificate of completion.

NOTE: Please, DO NOT submit the certificates of completion with this form.

Faculty:

_____
Print Name

_____
Signature