Print Student's Full Name: _____

Student/Intern at CENTRA Demographic Form

Please complete as appropriate.

Student/Intern Name*	
Address (street, city, state, zip)*	
Last four numbers of SSN & Birth Date*	
Is student under 18 years of age? *	____ No ____ Yes (Please attach signed Parental Permission form)
Home Phone*	
Alternate Phone	
E-mail Address*	
Emergency Contact Name & Relationship*	
Emergency Contact Phone*	
Name of School/ College/University/ or indicate if physician shadowing a physician, or if job shadow for employment.*	STEM Academy
Graduate/Undergraduate*	____ Undergraduate ____ Graduate ___X_ High School ____ Other (_____)
Major/Internship/Observation Focus*	Medical Internship
• Is student receiving class credit for time at Centra?* • Is this a long term shadowing experience?(more than 10 hours) • Is this a short term shadowing experience? (less than 10 hours)	___X_ Yes (answer b) ____ No ____ Yes (answer b) ___X_ No ____ Yes (answer b) __X__ No
Facility (example. VBH, Summit) & Dept.*	LGH/PCC/Central Virginia Regional Simulation Center
If interning/externing, who is your preceptor? If shadowing please indicate who you are shadowing.*	Lisa Stewart
Work Schedule/Hours	7:30 a.m. -11:30 a.m. each Wednesday

Start and End Dates of experience/internship*	January- May, 2017
Uniform Requirements	Business Casual with closed toed shoes
Below for Centra use Only	
Human Resources (if applicable)	Date: _____ Time: _____ Signature:_____
Employee Health • The student has fulfilled the health screening requirements	Date: _____ Time: _____ Signature: _____
Security: For Obtaining ID Badge if needed	Centra Intern badge will be provided to each student. Must be returned on the last day of the internship.
General Orientation (eHealthcareIT)	On-line Orientation Required: __X_ Yes ___ No Completed: _____
Computer use required for internship? Forms emailed to INFOSEC?	_____ Yes ____X_ No _____ Yes ___X__ No
Signature of Sponsor and Dept.	

CENTRA Student Behvaior Rules and Policies

By signing below, the intern/student understands that failure to follow the rules and policies of Centra will result in the termination of their learning experience.

Students, interns and observers must comply with all laws, rules, regulations and Centra policies and procedures including but not limited to the Centra Code of Conduct, Organizational, Administrative policies, and those listed below:

1. **Patient or Family Permission** must be obtained prior to a student/intern/observer being allowed access to a patient to assist in treatment or to observe treatment. It is the Centra sponsor/preceptor's responsibility to obtain this permission. (Informed Consent ORG. 01.01.02)

2. **LGBT Patient Policy:** All staff, students and interns are expected to respect the sexual orientation and identity of the patients assigned to them.(LGBT Policy CLIN.20.06.64)

3. **Solicitation:** Centra prohibits the solicitation, distribution, emailing and posting of materials on or at Centra property, including computers and other technology equipment, except as permitted by policy.(Solicitation ORG.03.01.16)

4. **Religious Solicitation:** Centra is a non-religious organization committed to ensuring a culture of professionalism. Centra workforce members, interns, and students may not engage in religious solicitation of patients and their families. Unsolicited visitation of patients and family members by clergy of any faith group, religious organizations, or sects is not permitted for any purpose unless specifically requested by the patient or family member. (Professional Boundaries ORG.03.01.32)

5. Fraternization between preceptors and student/interns is highly discouraged. (Harassment – Free Workplace V5 ORG 03.02.05)

6. **Dress Code**: For Clinical rotations follow the departmental dress code. For all others business casual with closed toed shoes unless instructed otherwise. (Dress Code ORG 03.03.08)

7. **ID Badges:** All Interns are issued Centra ID badges and are to wear them. They are to be returned to Security or to their preceptors at the end of the internship. All Observers are to wear their student ID badges from their schools or a temporary ID badge from the Office of Medical Education and Student Affairs. (Identification Badges ORG03.03.10)

8. **Cell Phone Use**: Intern/Student will not use personal cell phone for taking pictures, calls or texting in patient or public areas or while performing internship duties. Intern/Student may carry a cell phone for emergency use only. (Confidentiality/HIPPA ORG 05.01.08)

9. **Direct Patient Care Restrictions**: The Intern/Student will not participate in any hands-on or direct patient care activities unless supervised by licensed staff through a formal internship program with an accredited school or university. **Individuals shadowing or observing may not participate in any direct patient care activities under any circumstances**. (Code of Conduct and Business Ethics AC-2013.07)

10. **Confidentiality/HIPPA:** It is the responsibility of all student interns to protect the confidentiality of patients and families. Any perceived breach must be reported per Centra policy ORG.05.01.08, and students will be held to the same sanctions as employees.

11. **The following is not permitted at Centra:**

- Acceptance of money or valuable gifts from patients, families, vendors, or other work related parties is not allowed.
- Being under the influence or possessing drugs or alcohol.
- Deliberate destruction or misuse of property.
- Fighting or other disorderly conduct.
- Insubordination or failure to carry out supervisor instructions.
- Leaving work area without permission.
- Theft, fraud, or misappropriation of property.
- Threatening, intimidating or coercing others by words or deeds, or use of vile or abusive language.
- Unauthorized accessing, discussions, and/or release of confidential information concerning patients or employees.
- Abuse or inconsiderate treatment of patients.
- Gambling.
- Possession of weapons

***Complete copies of all policies referenced above are available from Corporate Compliance*

Liability Insurance Requirements for Students with Hands-On Clinical Experience

1. All interns/students from outside organizations are responsible for providing their own malpractice liability insurance. The college or educational facility that has the student affiliation agreement with Centra may provide student liability insurance. Centra assumes no responsibility for malpractice liability insurance coverage for interns from outside organizations. Centra Corporate Compliance must approve ANY exception to this policy.

Signature: _____ Date: _____

Print Name: _____

Print Student's Full Name: _____

Parent Permission Form for Students Under 18 Years of Age

I have read the rules and policies and expectations of student conduct pertaining to this internship for STEM Academy students and I grant permission for my son or daughter, _____, to participate in a learning experience at CENTRA. I am aware that the time spent is in a healthcare environment and its inherent risks.

Signature of Parent or Guardian: _____

Print Name of Parent or Guardian: _____

Date: _____

Print Student's Full Name: _____

Tuberculin Skin Test (TST) Permission Form

Parents, PLEASE NOTE:

Each student is required to have a current Tuberculin Skin Test (TST) to be eligible to participate as a student intern at CENTRA, as well a completed Employee Health Form on file. If the student has had a TST administered and **read after August 1, 2016** *(or is a current Centra volunteer or attended the Health Career Camp, summer of 2014)* a TST is not required providing the student submits the appropriate documentation from the physician office to include:

- Date the test was administered
- Date it was read,
- Name and signature of the person that read the results
- Results of test, positive or negative.

An Employee Health Form is attached and must be completed in full, documenting current health status and immunization record *(not required if student is a current Centra volunteer or attended the Health Career Camp, summer of 2015).* **Please note that Centra requires that each child have received two Varicella vaccines (chicken pox) and two MMR vaccines (measles, mumps and rubella) as well as proof of having received the current flu vaccine for 2016-2017 flu season.**

Healthworks will provide TB skins tests for students and interns on a self-pay basis only. The charge will be $26.00 and they accept cash, Visa and Master Charge ATM debit and credit cards. It will need to be paid when you register and check in at the front desk for the health appointment. A TB screening sheet is enclosed if this is an option you would like to choose and a parental consent form as well.

By signing below, I understand the above requirements:

Signature of Parent or Guardian: _____ Date: _____

Printed Name of Parent or Guardian: _____

_____

HealthWorks
work strong. live well.

Date:

To: Parent/Guardian

Subject: Consent for Vaccination/Testing

I give permission and consent to the Healthworks office physician or nurse to administer examinations, treatment or testing that is deemed medically necessary to meet the CDC/OSHA requirements for Healthcare facilities including the administration of the following tuberculosis skin test and/or vaccination(s) to my child.

☐ TDAP
X TB skin test
☐ Hepatitis B
☐ MMR (Measles, Mumps & Rubella)
☐ Varivax (Chicken pox)
☐ Flu Vaccine

_____
Name of Child

_____ _____
Parent/Guardian Signature Date

New Hire Step #1 ☐ #2 ☐ **Required Update** ☐ **Exposure** ☐

PLEASE REMEMBER TO MEET THE MANDATORY REQUIREMENT FOR EMPLOYMENT
THIS FORM MUST BE RETURNED TO EMPLOYEE HEALTH

NAME: _____ **Employee #:** _____

DEPT: _____ **Date of Birth:** _____

Have you developed any of the following medical conditions that may impact your ability to perform your job functions since your last employee screening? ☐ **YES** ☐ **NO If yes, describe below:**

_____

Are you experiencing any of the following symptoms at this time?

☐ Loss of appetite	☐ Chest pain	☐ Fever (generally at night)	☐ Productive cough
☐ Unexplained weight loss	☐ Night Sweats	☐ Fatigue	☐ Hemoptysis

Please answer the following questions:

Do you have a fever at the present time?	☐ YES ☐ NO
Has BCG vaccine (TB vaccine) ever been administered to you?	☐ YES ☐ NO
Are you taking steroids or cancer drugs?	☐ YES ☐ NO
Have you had a viral infection within the last 8 weeks due to (Measles, Mumps, Influenza, etc)?	☐ YES ☐ NO
Have you had a live virus vaccination within the last 8 weeks (Measles, Mumps, Polio, Influenza mist, Yellow fever, Small Pox)?	☐ YES ☐ NO
Have you ever had a POSITIVE reaction to a Tuberculin Skin Test?	☐ YES ☐ NO

I have answered the above questions to the best of my knowledge. I understand that the above questions will only be used to determine if a TST can be administered. I consent to TST administration if not contraindicated due to past positive reactions.

Signature: _____ Date: _____

SELF READING IS NOT ACCEPTABLE

Date Given: _____ Site: _____ Date Read: _____

Manufacturer: ☐ JHP ☐ Sanofi Pasteur Result: _____ MM

Lot#: _____ Exp. Date: _____ Reader Signature: _____

Administered By: _____ **May be read by any RN/LPN**IF NO REACTION****

READ AFTER _____ / _____ **AND BEFORE** _____ / _____

DATE TIME DATE TIME

FOR ANY SITE REDNESS OR INDURATION REPORT IMMEDIATELY TO EMPLOYEE HEALTH

Site care: Blot gently, **NO** lotion/cream to area, **NO** scrubbing or scratching, **OK** to shower/swim

Mini - Affiliating Health Record

☐ **Shadow (0005)** ☐ **Intern (0005)** ☐ **Student (0005)** ☐ **Other**

Start Date: _____ **End Date:** _____ **E-mail Address:** _____

Assignment/School: _____ Dept/Contact Person/Ph#: _____

Name: _____ DOB: _____ Sex: _____

Address: _____
(Street) (City) (State) (Zip)

SSN#: _____ Phone H/C: _____ Primary MD: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact H/C Ph#: _____ Emergency Contact Work Ph#: _____

Health Information

Height: _____ Weight: _____ BP: _____ Pulse: _____

Do you use tobacco products? **Yes** ☐ **No** ☐ If yes, how many packs per day? _____

List medications taken regularly: _____

Do you have any chronic illnesses? ☐ **Yes** ☐ **No** If yes, explain: _____

Allergies to Medications / Food: _____

List any operations or injuries? _____

Personal Health History: Please check all that are appropriate relating to your health.

☐ Anemia	☐ Emphysema	☐ Migraines
☐ Anxiety	☐ Fainting	☐ Mononucleosis
☐ Arthritis	☐ German Measles	☐ Mumps
☐ Asthma	☐ Hay Fever	☐ Pneumonia
☐ Back Problems	☐ Heart Trouble	☐ Red Measles
☐ Cancer	☐ Hepatitis	☐ Seizures
☐ Chicken Pox	☐ Hernia	☐ Skin Problems
☐ Depression	☐ High Blood Pressure	☐ Tuberculosis
☐ Diabetes	☐ Kidney Disease	☐ Ulcers

Ishihara Color Blindness Testing: Normal ☐ Abnormal ☐

OFFICE USE ONLY-PLEASE ATTACH IMMUNIZATION RECORDS

MMR Vaccination & Booster **#1** _____ **#2** _____ Titer Pending: ☐

Varicella (Chicken Pox) Vaccine **#1** _____ **#2** _____ Titer Pending: ☐

Hepatitis B Vac: **# 1** _____ **# 2** _____ **# 3** _____ CAT III ☐ Titer Pending: ☐

Influenza Vac: _____ **Tetanus/Diptheria/Pertussis Vaccine:** _____

Last TST Date: _____ **Result Date:** _____

Healthworks Nurse Signature _____ Date: _____

Directions for Completing the CENTRA Media Release Form

This form is to be completed by the parent for the student and should be filled out in the following manner:

I, *Parent name (for child's name)*
Address: *Parent's address*
Telephone: *Parent's home and work phone numbers*

Witness my signature on this, the *25th* day of *August*, 20*16* ***(date, month and year are only examples)***
Signature: *Parent's Signature*
Witness: *CENTRA Employee, so please leave blank*

Name of Minor: *Please print child's name*
Witness: *CENTRA Employee, so please leave blank*

Indicate for which facility (please check): *Check both hospitals*
Other: *Please write in Centra Facilities*

Reason Consent Required: *Publicity*

CENTRA
Medical Education
& Student Affairs