

## CENTRA Demographic Form for Student Short-term Observational Experiences

Please complete as appropriate.

Student Name*	
Address (street, city, state, zip)*	
Last four numbers of SSN & Birth Date*	
Is student under 18 years of age? *	<input type="checkbox"/> No <input type="checkbox"/> 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	XLR8 STEM Academy
Graduate/Undergraduate*	<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input checked="" type="checkbox"/> High School <input type="checkbox"/> Other (_____)
Major/ Observation Focus*	School Field Trip
<ul style="list-style-type: none"> <li>• Is this a short term shadowing experience? (less than 12 hours)</li> </ul>	<input checked="" type="checkbox"/> Yes (answer b) <input type="checkbox"/> No
Facility/CMG Practice/Department where observation will occur*	Lynchburg General Hospital
Who are you shadowing at Centra?*	
Hours scheduled to shadow?	
Date Scheduled to shadow*( may be approximate)	February 2020
Uniform Requirements	Business Casual

Below for Centra use Only	
Human Resources (if applicable) Background Check	Date: _____ Time: _____ Signature: _____
Health Works- Health Forms Sent	Date: _____  Signature: _____
General Orientation (eHealthcareIT)	On-line Orientation Required: ___ Yes ___X_ No
Forms Received in Student Affairs Dept.	Date:
Name person who collected forms	

## Centra Confidentiality Agreement No Computer Access

Effective security and confidentiality is a team effort involving the participation and support of every Centra Health employee and affiliate who deals with information and/or information systems. It is the responsibility of all users to know these guidelines and to conduct their activities accordingly.

Centra Health's policy is that all information is confidential, including, but not limited to patient diagnoses or courses of treatment, physician or other professional activities, Centra Health procedures, or financial and operating statistics. This policy applies whether the information is obtained through verbal, written, or electronic means. Information is to be accessed only on a "need to know" basis. The term "need to know" means the information is essential for performance of work responsibilities at Centra Health.

By my signature, I acknowledge that I have read the Confidentiality Policy and I understand the content and importance of these policies. I accept the responsibility that is placed on me as a Centra Health employee or affiliate to comply with these obligations and agree to abide by the policies of Centra Health as outlined in in the online orientation. I understand and agree that my obligation to maintain the confidentiality and security of the information shall continue after my relationship with Centra Health ends. I will contact Corporate Compliance if I have questions about policies or to request a paper copy of policies.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Typing your name on the line above constitutes an electronic signature under Virginia Code 59.1-485.

### **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. The following is not permitted:

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

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

### **Observer Conduct**

1. Observers will follow the departmental dress code.
2. Centra "Student" ID badges are not to be worn when students are observing outside of clinical rotations.
3. Observers will not use personal cell phone for taking pictures, calls or texting in patient or public areas or while observing patient care. Observers may carry a cell phone for emergency use only.
4. The Observer will not participate in any hands-on or direct patient care activities.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Typing your name on the line above constitutes an electronic signature under Virginia Code 59.1-485.

Print Name: \_\_\_\_\_

**Parental Permission Form for Students Under 18 Years of Age**

I have read the Rules and Policies pertaining to Observers at Centra, 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 health care environment and its inherent risks.

Signature of Parent/Guardian: \_\_\_\_\_

Typing your name on the line above constitutes an electronic signature under Virginia Code 59.1-485.

Print Name of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_



**Healthworks**  
 125 Nationwide Drive  
 Lynchburg, Virginia 24502  
 Phone: (434) 200-6939  
 Fax: (434) 200-6934

**Certificate of Health  
 Short Term Observation Education Experience**

I certify that I do not have any health problems that may pose a risk to hospital patients or staff. I am free from contagious or infectious disease, do not have any symptoms of illness and am feeling well.

Signature: \_\_\_\_\_

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

Social Security Number: \_\_\_\_\_  
(Required-Used for record keeping and compliance tracking purposes only)

Parental Signature: \_\_\_\_\_

Centra Site/Campus: Centra Facilities

Centra Preceptor: Lisa Stewart

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

**You must provide a record of a TB Skin Test (TST) that has been administered and read within the last 12 months and remain current during your observation time at Centra.**

Thank you,  
 HealthWorks/Centra Employee Health

Nurse Signature: \_\_\_\_\_

Date : \_\_\_\_\_

Short term observation is defined as twenty (20) hours or less.



## Affiliating Health Record

Student (0005)

Volunteer (0003)

**Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

School/College: STEM Academy

Centra Site/Campus: Centra Facilities

Centra Preceptor: Lisa Stewart

Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

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

Social Security Number: \_\_\_\_\_  
(Required-Used for record keeping and compliance tracking purposes only)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone: \_\_\_\_\_  
(Home or Cell)

Signature: \_\_\_\_\_

**OFFICE USE ONLY-PLEASE ATTACH IMMUNIZATION RECORDS**

<b>MMR Vaccination &amp; Booster</b>	<b>#1</b>		<b>#2</b>		<b>Titer Pending:</b>	<input type="checkbox"/>	
<b>Varicella (Chicken Pox) Vaccine</b>	<b>#1</b>		<b>#2</b>		<b>Titer Pending:</b>	<input type="checkbox"/>	
<b>Hepatitis B Vac:</b>	<b># 1</b>		<b># 2</b>		<b># 3</b>	<b>CAT III</b> <input type="checkbox"/>	<b>Titer Pending:</b> <input type="checkbox"/>
<b>Influenza Vac:</b>				<b>Tetanus/Diphtheria/Pertussis Vaccine:</b>			
<b>Last TST Date:</b>			<b>Result Date:</b>				
<b>Healthworks Nurse Signature</b>					<b>Date:</b>		



HEALTHWORKS  
 Phone (434) 200-6939  
 Fax (434)-200-6934

Step #1  Step#2  Required Update  Exposure

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

NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

DEPT: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Are you experiencing any of the following tuberculosis 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 (Vaccine is **NOT** routinely given in the USA) 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 OF THIS TB SKIN TEST IS NOT ACCEPTABLE**

**OFFICE USE ONLY**

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





**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
- TB skin test
- Hepatitis B
- MMR (Measles, Mumps & Rubella)
- Varivax (Chicken pox)
- Flu Vaccine

\_\_\_\_\_  
Name of Child

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date