

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? *	<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/ or indicate if physician shadowing a physician, or if job shadow for employment.*	STEM Academy
Graduate/Undergraduate*	<input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate <input checked="" type="checkbox"/> High School <input type="checkbox"/> Other (_____)
Major/Internship/Observation Focus*	Medical Internship
<ul style="list-style-type: none"> • 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) 	<input checked="" type="checkbox"/> Yes (answer b) <input type="checkbox"/> No <input type="checkbox"/> Yes (answer b) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (answer b) <input checked="" type="checkbox"/> 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, 2021
Uniform Requirements	Business Casual with closed toed shoes. You will be sent home to change if you do not comply with uniform requirements.
Below for Centra use Only	
Employee Health The student has fulfilled the health screening requirements	Date: _____ Time: _____ Signature: _____
Security: <ul style="list-style-type: none"> • 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: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Completed: _____
Signature of Sponsor and Dept.	

CENTRA Student Behavior 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. Fraternalization 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: _____

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.

******If computer use is required for internship, please complete MIS Non-Employee Confidential Access Form and Centra Health Confidentiality and Acceptable Computer Use User Agreement as well.**



CENTRA

Medical Education
& Student Affairs

Dear Student:

Under FERPA (The Family Educational Rights and Privacy Act), you have the right to provide written consent before personally identifiable information is released from your student education record. In this case, we are requesting your written consent to release information about your rotation schedule to other students who will be rotating at the same site.

If you opt to release your information, the following information may be disclosed to other students:

- Your rotation schedule (includes time/location of events)
- The name of the preceptor with whom you will be rotating
- Any changes that may occur to your schedule
- Your email address

Some benefits to authorizing this disclosure include:

- Students may be aware of other students rotating at the same location
- Student could more easily exchange information about rotations
- Students would be able to coordinate travel
- Students could communicate efficiently to make scheduling swaps/adjustments if needed
- Preceptors could view student schedule as a whole

Please sign below, to permit the release of this information to other students.

Parent or eligible student signature:

(Eligible student is defined as 18 or older)



CENTRA

Consent To Release Information Through Interviews, Print Media, Photographs, Motion Picture, Video Production, Radio & Television

I, _____
(please print name)

Address: _____
(street) (city) (state) (zip)

Telephone: _____
(area code) (home) (area code) (work)

give to Centra, its employees, physicians, volunteers and other people officially working on behalf of Centra, consent and permission for an interview and/or photograph(s), still or film, for purposes of publication in newspapers, magazines or other printed media, or for broadcast by means of video, motion picture, radio, television or internet transmission. I relieve and agree not to hold Centra liable for the interviewing and photographing, and subsequent publication or broadcasting. I understand that the interviewing and photographing are being carried out with my consent, and I assume responsibility for my consent.

Witness my signature on this, the 10th day of August, 2018

Signature: _____

Witness: _____
(name) (date)

Note: If individual involved in this release form is a minor, the parents or guardian should complete this consent form.

Name of Minor: _____

Witness: _____

Indicate for which facility (please check):

Centra Lynchburg General Hospital Centra Virginia Baptist Hospital

Other: Centra Facilities
(write name of facility)

Reason Consent Required: Publicity

Any questions about this consent form may be directed to the Communications/Marketing Department at Centra, 1920 Atherholt Road, Lynchburg, VA 24501 • 434.200.4730.



Affiliating Health Record

Student (0005)

Volunteer (0003)

Start Date: 1/9/2019 End Date: 5/1/2019

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

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



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?

- | | | | |
|--------------------------------------------------|---------------------------------------|-----------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fever (generally at night) | <input type="checkbox"/> Productive cough |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hemoptysis |

Please answer the following questions:

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|
| Do you have a fever at the present time? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Has BCG vaccine (Vaccine is NOT routinely given in the USA) ever been administered to you? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Are you taking steroids or cancer drugs? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you had a viral infection within the last 8 weeks due to (Measles, Mumps, Influenza, etc)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you had a live virus vaccination within the last 8 weeks (Measles, Mumps, Polio, Influenza mist, Yellow fever, Small Pox)? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you ever had a POSITIVE reaction to a Tuberculin Skin Test? | <input type="checkbox"/> YES | <input type="checkbox"/> 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



HealthWorks

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

Name of Child

Parent/Guardian Signature

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, 2017** (*or is a current Centra volunteer or attended the Health Career Camp, summer of 2017*) 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 2017*). **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 2017-2018 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 the day of orientation. 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: _____
