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?*	___X_ Yes (answer b) ____ 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/Hour	7:30 a.m. -11:30 a.m. each Wednesday
Start and End Dates of experience/internship*	January- April, 2021
Uniform Requirements	**Business Casual with closed toed shoes.** **You will be sent home if not dressed appropriately.**

Student Behavior Policies and Rules

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 (any amount) or gifts of any kind of greater than nominal value ($50) from patients, families, vendors, or other work-related parties is not allowed. There is an allowance made for the receipt of gifts (no cash) so long as they are of "nominal" value (less than $50); are shared within the department (i.e., food or flowers); and are not real/perceived bribes and/or inducements. Refer to Code of Conduct and Business Ethics AC-2013.07, policy on Gifts and Contributions to Centra GG-2013.16 and policy on Tips, Gifts and Gratuities ORG.03.03.21.
    - 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*

<u>Liability Insurance Requirements for Students with Hands-On Clinical Experience</u>

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 and understand the Rules and Policies pertaining to Students/Interns at Centra, and I grant permission for my son or daughter, ____, to participate in a learning experience at Centra. I am aware that the learning experience is taking place in a health care environment. I understand that participation is purely voluntary.

I acknowledge and understand that being in a health care environment has inherent risks. With knowledge of these risks, I hereby: (1) waive and release Centra and its employees/agents from all liability and claims arising from any damages, injury, or harm (including property loss/damage) in connection with my son's/daughter's learning experience at Centra; and (2) agree to indemnify and hold harmless Centra and its employees/agents from any claims arising from the learning experience at Centra which (i) I or my son/daughter might make, (ii) might be made on my behalf or my son's/daughter's behalf by others, or (iii) might be made against me or my son/daughter by others.

I understand that I am responsible for ensuring that my son or daughter behaves appropriately during this learning experience at Centra. I further understand that, if in the opinion of Centra personnel, my son or daughter is not behaving appropriately, I may be asked to and agree to pick-up my son or daughter early from the experience at my own expense.

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: ________________________________

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)

Print Student's Full Name: ____

Tuberculin Skin Test (TST) Permission Form

Parents, PLEASE NOTE:

Each student is required to have certain health forms and immunizations and TB Skin Test (TST) on file with Centra to participate as an intern or camper at Centra. If the student has had a TST administered and **read after August 1, 2020**, *or is a current Centra volunteer or attended the Health Career Camp, summer of 2020,* 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.

A Mini-Affiliating Health Form is included in this packet and must be completed. Centra also needs a copy of your child's immunization record from your physician's office. **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 2018-2019 flu season.**

By signing below, I understand the above requirements:

Signature of Parent or Guardian: ________________________________ Date: ______________

Printed Name of Parent or Guardian: _____________________________________

___

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 *14th* day of *September*, 20*20* ***(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

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 ____________ day of ____________________, 20 ________

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: ____
(write name of facility)

Reason Consent Required: ____

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: January 2021 **End Date:** April 2021

School/College: ______________________

Centra Site/Campus: ______________________

Centra Preceptor: ______________________

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:	☐
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:		

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: ______________

May be read by any RN/LPNIF NO REACTION****

Administered By: ______________________

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