ARCHBOLD MEDICAL CENTER

P. O. Box 1018 • Thomasville, GA 31799-1018

STUDENT/INSTRUCTOR/NURSING RE-ENTRY CLINICAL CLEARANCE FORM

Route request to Departmental Clinical Contact
*******Please allow 2 WEEKS for account creation*******

Creation of user name only applies for one semester/quarter. A new request must be submitted each quarter/semester unless otherwise arranged.

Please check one of the following: ☐ New account (**If an Instructor provide DOB_____**)
☐ Returning Student/Instructor username**:** _____
☐ Correct Existing Account (please describe correction needed)
☐ Account Deletion/Inactivation (mid quarter/semester dismissal only)

Computer/System access requested: ☐ **NO access needed** ☐ **Soarian Clinicals** ☐ **MAK (Med Admin)**

Student Full Name: _____
(Please print) First Middle Last
Middle Initial and ID# MUST be included before a login can be issued

Student contact number: _____

Student ID:_____ **School:** _____

Instructor's Name, Phone #, & E-mail: _____

Rotation Dates - Start: _____/_____/_____ **End:** _____/_____/_____

Course of Study: (Please check one): ☐ **Clinical Rotation** ☐ **Preceptorship**, *if yes,*
Assigned Preceptor Name: _____ Unit:_____ Shift: _____
☐ RN ☐ LPN ☐ Respiratory ☐ Radiology ☐ Surgery ☐ Lab ☐ Business Office ☐ Cardio Tech
☐ Dietetics ☐ Pharmacy ☐ Medical Student ☐ Other: _____
☐ Therapy (select one): ☐ Physical ☐ Occupational ☐ Speech ☐ Recreational
☐ Nursing Re-Entry (NOTE: A copy of your nursing permit is required)
☐ Paramedic ☐ Medical Records ☐ Social Worker
Facility/Site(s): _____ **Dept/ Unit(s):** _____

By signing this form, I, the instructor, certify the student is current with the following REQUIRED clinical clearance items through this semester/quarter, check all that apply (includes Archbold employees):

☐ BLS (American Heart) ☐ HIPAA Training ☐ Current Immunizations ☐ Flu Shot (during Flu Season)

☐ Student Liability Insurance current

☐ Orientation packet completed & signed

☐ PPD Date completed - _____/_____/_____. ☐ PPD neg. (☐ PPD pos. / ☐ Previous pos. / (follow-up required))

Within 2 yrs after school's admission date:

☐ **Drug screening** - (☐ Negative/ ☐ Positive/(results submitted to coordinator))

☐ **Background Check** completed by Pre-Check & submitted to Archbold's student coordinator for approval. **If Pre-Check was not used for the background check, a copy *MUST* accompany this form**

Instructor's Signature **Date** **Student's Signature**

Special accommodations (e.g. Latex Free): _____

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STUDENT CONFIDENTIALITY AND NON-DISCLOSURE STATEMENT

All information pertaining to patient records, condition, personal details, and computer security is confidential. User names and passwords are not to be shared with anyone. Student is not to use his/her access to get information on patients or employees outside the student's direct care.

I, _____, a student/instructor in clinical rotation at Archbold Medical Center, acknowledge that I have reviewed and understand the policies set forth below. I have read, signed and agreed to abide by the Archbold Medical Center's Confidentiality Statement.

- I understand that all patient information in any format, including billing and financial data, is confidential.

- I agree to keep patient information confidential.

- I understand that my computer login ID is the equivalent of my legal signature, and I will be accountable for all representations made at login and for all work done under by login ID. I understand that data and information stored in the Medical Center's computer systems is confidential patient, financial, and organizational information, and I must treat it with the same care as data and information in paper records.

- I will safeguard my computer login ID and password at all times. If I believe the security of my login ID and password has been compromised, I will immediately contact my instructor.

- I agree to comply with all Health System Privacy Policies and Procedures including those implementing the HIPAA privacy rule. I understand specific policies and procedures exist regarding the release of medical record information and release of patient condition information. Such information is to be disclosed only by designated individuals and in accordance with specified procedures in Administrative Policies #105.06, "Release of Medical Record Information" and #101.02, "Release of Patient Condition Information."

- I understand that I will not access information regarding myself, family members, friends, patients, fellow students, employees, or members of the medical staff, unless it is relevant to the performance of my clinical rotation. I understand that I am to follow established Medical Record Department procedures to obtain clinical information from my individual medical record just as any other patient does.

- I understand if I have any question or concerns about the Privacy Rule and /or the proper use of the disclosure of patient information, I should ask my Instructor or clinical supervisor or the Medical Center's Privacy Officer/Compliance Officer.

- I understand and agree that the Health System Privacy Policies and Procedures will apply to any patient information I have access to at the Health System even after I complete my rotation or other relationship with Archbold Medical Center.

Student Signature: _____ Date: _____

(Please Print)
Name: _____ School: _____