Winneshiek MEDICAL CENTER | Physician services by MAYO CLINIC HEALTH SYSTEM

Student Intern Orientation Acknowledgement

Student name: _____

Please initial each line item you have reviewed.

Initial	Role of the Student at Winneshiek Medical Center
Initial	Mission, Vision and Values
Initial	Name Badge
Initial	Tobacco Free Campus
Initial	Parking
Initial	Timeliness / Attendance
Initial	Background Screening
Initial	Conduct and Behavior, Alcohol and Drugs
Initial	Phones and Mobile Devices
Initial	Dress Code, Tattoos, and Personal Hygiene
Initial	Customer Service / Courtesy
Initial	Covid Vaccine proof
Initial	Diversity and Inclusion and Language Services
Initial	General Safety, including Preventing Falls, Abuse Reporting, and Incident Reports
Initial	Fire Safety
Initial	Safety Codes
Initial	Infection Control, Hand Hygiene and Hand washing Procedures
Initial	Blood Borne Pathogens and Standard Precautions
Initial	Immunizations and Flu shot requirement
Initial	Personal Illness Reporting and Covid – 19 precautions
Initial	Confidentiality, Privacy, and HIPAA & Confidentiality Video Watched
Initial	Completed Student Information Form & Immunizations
Initial	Completed Confidentiality form attached (with parent / guardian signature if under 18)
Initial	I understand that this orientation packet is valid for the current school year (July 1 – June 30). If I have another assignment here again after June 30, I will repeat this orientation and provide new paperwork to Winneshiek Medical Center.

****What was the image of at the end of the orientation that you were asked to remember? _____**

By signing this document, I agree that I have reviewed and understand the expectations, policies and procedures included in the student orientation on the above topics. I agree to provide a copy of my photo ID to WMC (school ID, driver's license, or other legal photo ID).

_____

Student Signature Date

RETURN THIS PACKET TO education@winmedical.org or fax to 563-382-1962 Rev 03/30/2022

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STUDENT INFORMATION SHEET –STUDENT INTERN

Name: _____ Today's Date: _____

DEPARTMENT YOUR INTERNSHIP WILL BE IN: _____DOB: _____

DATES OF EXPERIENCE:_____

Email Address: _____ Cell Phone Number:_____

Current Address: _____City: _____ State: _____ Zip:_____

Permanent Address: _____City:_____ State: _____Zip: _____

Emergency Contact: _____ Relationship:_____ Phone#_____

School Affiliation (if applicable): _____

IMMUNIZATIONS: The safety of our staff, patients and guests is important to us.
Please provide official proof of record for the following immunizations or titers with this packet:

_____ TDAP
_____ Hepatitis B and MMR
_____ Current year Influenza (for experiences from October 1 – March 31)
_____Baseline Two step TB within 5 years (plus CDC form if has been more than 1 year since two step Mantoux)
_____ Varicella (or year had disease)
_____ Covid Vaccine and Booster proof

_____ BLS certification (for patient care)
_____ Copy of Background check (if applicable)

OTHER REQUIREMENTS:

VERIFICATON (office use only)	
	Photo ID Verification (DL/ School ID)
Other WMC notes: _____ IT login _____ FOB	_____School contract verified (if applicable)

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Confidentiality Agreement

Competency Statement
All WMC personnel including employees, volunteers, students, contracted services and medical staff will demonstrate an understanding and commitment to the protection of patient privacy and the confidentiality and security of health information.
Performance Criteria
I understand that the right of confidentiality applies to all patients and that all patient information is confidential (not just diagnosis and treatment) I understand that not all WMC employees are permitted access to patient records. I understand that persons who access patient information and other confidential data must have a legitimate reason (i.e. patient care or administrative audit) to know the information as it relates to their job function. I understand that elevators and other public areas are inappropriate places to discuss patient information and other confidential data even if a patient's name is not used. Such conversations may raise doubts among patients and visitors about our respect for their privacy. I am aware of the precautions and mechanisms used in my home department to safeguard confidential information including computer access, workstations and discussion. I will log off any computer or terminal prior to leaving it unattended. I understand that I am obligated to report security and privacy violations immediately to my supervisor or the compliance officer and when possible I will stop the security/privacy violation. I understand that my obligation under this competency continues after the termination of my employment. I understand that patients have a right to know how their health information is used and that patients must authorize the disclosure of their information except when the disclosure is required by law. I understand that patients have the right to restrict disclosure of their health information. I understand that patients have a right to recommend amendments and or request correction to their medical records. I understand that patients must specifically authorize the disclosure of information related to substance abuse, mental health, and HIV/AIDS. I will forward requests for health information to Health Information Management for appropriate processing, including facsimile requests, walk-in, telephone, etc. I will direct all medical record subpoena/court order requests to the Director of Health Information Management. I understand that all students and volunteers who have access to any information about patients will receive written orientation instructions regarding confidentiality and patient privacy prior to accessing such information. I understand that WMC considers intentional and unintentional breaches of patient information a very serious matter. Violations to security and privacy policies will result in appropriate disciplinary actions up to and including termination. I understand that by signing this document that I am agreeing to comply with the above terms. I confirm acknowledgement and receipt of the WMC policies and training related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I confirm that I am expected to understand and follow policies and procedures related to HIPAA completely. If concerns or questions arise, I may contact the privacy officer, the security officer, the compliance officer, my supervisor, or Human Resources without fear of retaliation.

_____	_____	_____
Print Student Name	Student Signature	Date
_____	_____	_____
Print Witness Name	Witness Signature	Date

Student / Volunteer Health Agreement

- As a student of Winneshiek Medical Center, I understand that it is my responsibility to follow all applicable health guidelines, protocols, and policies.
- I understand that I must notify my clinical instructor if I have a known exposure to COVID-19, a fever, or other COVID-19 symptoms. My instructor or supervisor will assess next steps and follow WMC's Can I come to work algorithm. If you need to be tested for Covid, WMC accepts any lab-derived test. No home tests will be permitted as evidence that you are Covid-negative.
- I understand and agree that I must complete a daily assessment of my symptoms and monitor my temperature prior to reporting to work to assure that I am able to work safely.
- I agree to follow my department or school notification process if I am unable to work for any reason. If I do not know this, I will ask my supervisor or clinical instructor.
- I attest that by reporting to work for my scheduled shift:
    - I do not have any known exposures to COVID-19 without proper PPE
    - I have not had a fever (>100 °F) at any point during the last 72 hours
    - I do not have recent respiratory or other COVID-related symptoms
        - Aches, chills, fatigue
        - GI distress (nausea, diarrhea, vomiting)
        - Respiratory distress (coughing, shortness of breath)
        - Headache
        - Sore throat
        - Loss of taste / smell
        - Sinus congestion
    - If I develop symptoms while at work, I will follow the WMC guidelines for reporting this to my clinical instructor or supervisor.
    - I do not have any other symptoms that would prevent me from working.

Student Name [Please print]:_____

Signature: _____

Date: _____