BON SECOURS CHARITY HEALTH SYSTEM
A member of the
Westchester Medical Center Health Network

Cover Sheet for Medical Staff Clinical Rotations

This form is designed to assist in expediting the clinical placement of medical staff, clinical rotation students. In accordance with Bon Secours Charity Health System's policies, we are asking that the faculty/student submits all requested documentation in one complete packet.

Name of Student: _____ Date:_____

Student Email: _____ Phone:_____

Preceptor/Department: _____Rotation Start Date: _____

School/Educational Institution: _____

School Contact/Coordinator: _____Email:_____

Last four digits Social Security Number: _____ Sizing for scrubs (unisex) top: _____ bottom: _____

I have reviewed the following information:

☐ Code of Conduct_____ ☐ Catholic and Religious Directives_____ ☐ Orientation Verification Attestation_____
Initials Initials Initials

I have attached the following documentation:

☐ Request for Observations, Internship or Clinical Rotation Privileges Form

☐ Confidentiality Agreement

☐ Health Assessment and physical examination report

☐ EMR / IT Security Access Form

☐ Code of Conduct for Custodians of People with Special Needs

☐ PPD Results (within one year) If PPD positive, a chest x-ray report must be included within the past 2 years.

☐ Rubella Titre

☐ Rubeola (Measles) Titre, if born after 1/1/1957

☐ Flu Vaccine for current season.

Submit this Cover Sheet with ALL required paperwork via Email

A representative from Bon Secours Charity Health System will contact the student for an in-person meeting prior to start of their Rotation. EMR (ConnectCare) training will also be required.

Submit all forms to:

Good Samaritan Hospital
Medical Student Education Coordinator
BSCHS_MedStaffStudent@bshsi.org
845.368.5585 (office) 845.368-5938 (fax)

Request for Observation or Clinical Rotation Privileges

Date: ____________________

In the interest of furthering my education regarding ____, I

_______________________ request to ☐ observe or ☐ perform a clinical rotation with ____________________.

If performing a clinical rotation, please indicate the school name: ______________________________________.

** A current executed agreement with Bon Secours Charity Health System, WMC Health Network must be on file.*

Requested time period from: ______/______/______ to ______/______/______.

Specialty: ___________________________________

The following terms and conditions of my hospital experience and status apply:

1. Observers – Absolutely **no hands-on patient care is to be provided by me at any time**.
2. Patients under the care of the physician are to be notified of my status.
3. Patient confidentiality must be maintained at all times as stipulated by the rules and regulations established by the Confidentiality Agreement regarding patient privacy as outlined in Federal Law.
4. I release, discharge and relieve Bon Secours Charity Health System and its' employees from any and all claims whatsoever of any nature arising out of / as a result of his / her participation with Bon Secours Charity Health System and all related activities.

Student attestation:
I agree to the terms as outlined above.

____ ________________________________
Student Signature Date

____ ________________________________
Email Mobile Phone

____ ________________________________
Emergency Contact Name Phone

Licensed Independent Practitioner (LIP), Site Director or Preceptor attestation:
I understand the above named observer / student has been granted permission as set by the terms and conditions described above. I understand that Observers will provide no hands-on patient care at any time.

____ ________________________________
LIP, Site Director or Preceptor Print Name Date

____
LIP, Site Director or Preceptor Signature

****

Authorized by:

____ ________________________________
System Director, Medical Staff Services or Designee, Print Name Date

____
System Director, Medical Staff Services or Designee, Signature

BON SECOURS CHARITY HEALTH SYSTEM
A member of the
Westchester Medical Center Health Network

Observer/Intern/Student Confidentiality Agreement

This Agreement (the "Agreement") is effective _____ day of _____, 20____,

Between_____facility") and _____ (Observer, Intern, Student),

to participate in clinical learning activities at facility. Observer agrees as follows:

Confidentiality Observer/Intern/Student acknowledges that as a result of the clinical learning activities, Observer/Intern/Student will have access to confidential information of the Facility, including patient health information. Observer/Intern/Student will hold confidential all patients and Facility information obtained as a participant in these activities and will not to disclose any personal, medical, related information, or any other confidential information to third parties, family members, or other Observers/Interns/Students and teachers, except as permitted in this Agreement or as required by law. Observer/Intern/Student is committed to protecting and safeguarding from any oral and written disclosure all confidential patient and Facility information that Observer/Intern/Students comes in contact with. Observer/Intern/Student shall not copy surgery schedules, patient medical records, or other Facility information. Except as permitted or required by this Agreement or by law, Observer/Intern/Student will not use or disclose patient information in a manner that would violate the laws of New York State or the requirements of any federal law, including, for example, the Privacy and Security Standards contained in the Health Insurance Portability and Accountability Act of 1996 (45 CFR §§ l60 through 164). Observer/Intern/Student expressly agrees to comply with state and federal law in all respects, and to implement of all necessary safeguards to prevent such disclosure. Observer/Intern/Student acknowledges that any breach of confidentiality or misuse of information will result in termination of Observer's clinical activities at Facility, as well as the potential termination of the Facility's relationship with Observer's/Intern/Students school or legal action. Unauthorized disclosure may give rise to irreparable injury to the patient or the owner of the confidential information and accordingly, the patient or owner of such information may seek legal remedies against the Observer/Intern/Student.

Compliance with Policies and Rules While participating in clinical activities at Facility, Observer/Intern/Student will abide by all applicable Facility rules, policies, procedures and instructions, whether verbal or written, including the Bon Secours Health System Code of Conduct. Observer/Intern/Student shall review the Facility's Administrative Policy Manual which includes information regarding bloodborne pathogens, hazardous chemicals, TB prevention, fire safety, electrical safety, and emergency preparedness. Observer/Intern/Student will wear appropriate attire, including an identification badge identifying him/her as an Observer/Intern/Student, as requested by Facility.

Release and Professional Liability Insurance Observer/Intern/Student will hold harmless the Facility, its parents, officers, directors, employees, members, and any and all of their affiliates, subsidiaries, employees, agents and insurers (collectively "Facility"), from any and all liability of whatsoever nature and from injuries, sickness or other damages, physical as well as emotional, suffered by Observer/Intern/Student during participation in the clinical activities. Observer/Intern/Student acknowledges that Observer/Intern/Student is covered by Observer's/Intern/Student own (or school's) professional liability insurance coverage and agrees to furnish proof of such coverage to Facility.

Limitation Observer/Intern/Student understands that by signing this Agreement, Observer/Intern/Student is not guaranteed participation in any clinical activities at Facility. Eligibility of participation shall be determined exclusively by Facility, in its sole discretion.

Withdrawal of Observer/Intern/Student Facility may require the Observer/Intern/Student to immediately withdraw from the clinical activities in the event Facility determines, in it sole discretion, that Observer/Intern/Student conduct, demeanor or cooperation is unsatisfactory or that Observer has violated Facility policies or rules, including, but not limited to, breach of confidentiality.

Observer/Intern/Student Status Observer/Intern/Student understands that Observer/Intern/Student is not and will not be considered an employee of Facility or any of its subsidiaries or affiliates by virtue of Observer's/Intern's/Student's participation in the clinical learning activities and shall not as a result of Observer's/Intern's/Student's participation in the clinical activities, be entitled to compensation, remuneration or benefits of any kind.

Observer/Intern/Student Signature:	Date
Facility Representative:	Date

Confidentiality and Security Agreement

BON SECOURS MERCY HEALTH

Bon Secours Mercy Health (BSMH) has a legal and ethical responsibility to safeguard the privacy of all patients, residents, and clients and to protect the confidentiality of their personal health information. BSMH must also protect the confidentiality of organizational information that may include, but is not limited to, human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems, and management information from any source or in any form including, without limitation, paper, magnetic or optical media, conversations, electronic, and film. For the purpose of this Agreement, all such information is referred to as "Sensitive Data."

I UNDERSTAND AND HEREBY AGREE THAT:

1. During my employment/affiliation with BSMH, I understand that I may have access and exposure to Sensitive Data.
2. I will access and / or use Sensitive Data only as necessary to perform my job-related duties and in accordance with BSMH's policies and procedures.
3. My User-ID and password are confidential, and in certain circumstances may be equivalent to my **LEGAL SIGNATURE,** and I will not disclose them to anyone. I understand that I am responsible and accountable for all entries made and all information accessed under my User-ID.
4. I will not copy, release, sell, loan, alter, or destroy any Sensitive Data except as properly authorized by law or BSMH policy.
5. I will not discuss Sensitive Data so that it can be overheard by unauthorized persons. It is not acceptable to discuss information that can identify a patient in a public area even if the patient's name is not used.
6. I will only access and / or use systems or devices I am authorized to access and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
7. I have no expectation of privacy when using BSMH information systems. BSMH has the right to log, access, review, and otherwise use information stored on or passing through its systems, including e-mail.
8. I will never connect to unauthorized networks through BSMH's systems or devices.
9. I will practice secure electronic communications by transmitting Sensitive Data in accordance with approved BSMH security standards.
10. I will practice good workstation security measures such as never leaving a terminal unattended while logged in to an application, locking up removable media when not in use, using screen savers with activated passwords appropriately, and positioning screens away from public view.
11. I will:
    a. Use only my assigned User-ID and password.
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
    d. Not attempt to learn or use another's User-ID and password.
    e. Not store sensitive data that is not in accordance with BSMH policy and standards.
12. I will disclose Sensitive Data only to authorized individuals with a need to know that information in connection with the performance of their job function or professional duties.
13. Unauthorized or improper use of BSMH's information systems and / or Sensitive Data, is strictly prohibited and may not be covered by BSMH's insurance or my personal professional malpractice insurance. **Any such violation may subject me to personal liability as well as sanctions for violation of state and federal law.**
14. I will notify my manager, BSMH Privacy Officer, IS Security, or other appropriate Information Services personnel if my password has been seen, disclosed, or otherwise compromised.
15. Upon termination of my employment / affiliation / association with BSMH, I will immediately return or destroy, as appropriate, any Sensitive Data in my possession.
16. Violation of this Agreement may result in disciplinary action, up to and including civil or criminal action, termination of employment / affiliation / association with BSMH, and suspension and / or loss of medical staff privileges in accordance with BSMH's policies.
17. My obligations under this Agreement will continue after termination of employment / affiliation / association with BSMH.

By signing this document, I acknowledge that I have read this Agreement, and I agree to comply with all the terms and conditions stated above.

Signature_____ Date _____

Printed Name _____

Non-BSMH Organization Name _____

OBSERVER and CLINICAL ROTATION ORIENTATION VERIFICATION

Please review the orientation documents by visiting our non-employee portal at
http://bschs.bonsecours.com/nonemporient

I have reviewed and understand the orientation module, Code of Conduct, Ethical and Religious Directives provided to me through the non-employee portal.

Signature: _____ Date: _____

Print Name: _____

STUDENT AGREEMENT

This Student Agreement (the "**Agreement**") is effective the _____ day of _____, 20___, between _____ ("**Facility**") and _____ ("**Student**"), a student currently enrolled at _____ (the "**School**") to participate in clinical learning activities at Facility. Student agrees as follows:

Confidentiality. Student acknowledges that as a result of the clinical learning activities, Student will have access to confidential information of the Facility, including patient health information. Student will hold confidential all patient and Facility information obtained as a participant in these activities and will not to disclose any personal, medical, related information, or any other confidential information to third parties, family members, or other students and teachers, except as permitted in this Agreement or as required by law. Student is committed to protecting and safeguarding from any oral and written disclosure all confidential patient and Facility information that Student comes in contact with. Student shall not copy surgery schedules, patient medical records, or other Facility information. Except as permitted or required by this Agreement or by law, Student will not use or disclose patient information in a manner that would violate the laws of the State of New York or the requirements of any federal law, including, for example, the Privacy and Security Standards contained in the Health Insurance Portability and Accountability Act of 1996 (45 CFR §§ l60 through 164). Student expressly agrees to comply with state and federal law in all respects, and to implement of all necessary safeguards to prevent such disclosure. Student acknowledges that any breach of confidentiality or misuse of information will result in termination of Student's clinical activities at Facility, as well as the potential termination of the Facility's relationship with Student's school or legal action. Unauthorized disclosure may give rise to irreparable injury to the patient or the owner of the confidential information and accordingly, the patient or owner of such information may seek legal remedies against the Student. Student shall agree to comply with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Rule") issued under the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), which govern the use and/or disclosure of individually identifiable health information.

Compliance with Policies and Rules. While participating in clinical activities at Facility, Student will abide by all applicable Facility rules, policies, procedures and instructions, whether verbal or written, including the Bon Secours Health System Code of Conduct. Student shall review the Facility's Administrative Policy Manual which includes information regarding bloodborne pathogens, hazardous chemicals, TB prevention, fire safety, electrical safety, and emergency preparedness. Student will wear appropriate attire, including an identification badge identifying him/her as a student, as requested by Facility.

Release and Professional Liability Insurance. Student will hold harmless the Facility, its parents, officers, directors, employees, members, and any and all of their affiliates, subsidiaries, employees, agents and insurers (collectively "Facility"), from any and all liability of whatsoever nature and from injuries, sickness or other damages, physical as well as emotional, suffered by Student during participation in the clinical activities. Student acknowledges that Student is covered by School's professional liability insurance coverage and agrees to furnish proof of such coverage to Facility.

Limitation. Student understands that by signing this Agreement, Student is not guaranteed participation in any clinical activities at Facility. Eligibility of participation shall be determined exclusively by Facility, in its sole discretion.

Withdrawal of Student. Facility may require the Student to immediately withdraw from the clinical activities in the event Facility determines, in it sole discretion, that Student's conduct, demeanor or cooperation is unsatisfactory or that Student has violated Facility policies or rules, including, but not limited to, breach of confidentiality.

Student Status. Student understands that Student is not and will not be considered an employee of Facility or any of its subsidiaries or affiliates by virtue of Student's participation in the clinical learning activities and shall not as a result of Student's participation in the clinical activities, be entitled to compensation, remuneration or benefits of any kind.

Ownership of Intellectual Property. All reports and other data (including without limitation, written, printed, graphic, video and audio material contained in any computer data base or computer readable form, but excluding

any academic or scholarly publications) (hereinafter "Works of Authorship") developed during the term of this Agreement and while on Facility's premises or using Facility resources or information are the property of the Facility. Works of Authorship created during the term of this Agreement are "Works for Hire", as that term is defined in copyright law. Facility shall own all rights to any inventions, discoveries, new uses, advances on the state of art, protocols, ideas, products or other protectable rights arising from the Student's participation in the clinical learning activities at Facility pursuant to this Agreement (hereinafter "Inventions"). Student shall execute all documents, provide all information, and otherwise take all actions requested by Facility, including, without limitation, assignments of rights, if any, Student may have in such works, to secure for Facility the ownership rights and available legal protections for all Works of Authorship or Inventions.

_____	_____
Student	Facility
Date: _____	Date: _____

CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

Revised January 21, 2016

Introduction

The Code of Conduct, as set forth in the Code of Conduct itself, sets forth a framework intended to assist impacted employees to help people with special needs "live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm," in addition to the specific guidance provided by the agency's policies and training.

Similarly, the Notice to Mandated Reporters contains guidance designed to assist mandated reporters, and is intended to provide a summary of reporting obligations for mandated reporters. It is not intended to supplement or in any way add to the reporting obligations provided by law, rule, or regulation.

As provided by law, rule, or regulation, only custodians who have or will have regular and direct contact with vulnerable persons receiving services or support from facilities or providers covered by the *Justice Center Act* must sign that they have read and understand the Code of Conduct.

The framework provides:

1. **Person-Centered Approach**

   My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where consistent with agency policy, their right to assume risk in a safe manner, and recognizing each person's potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever consistent with agency policy, I will work to support the individual's preferences and interests.

2. **Physical, Emotional and Personal Well-being**

   I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm to others and themselves.

3. **Respect, Dignity and Choice**

   I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and consistent with agency policy. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and consistent with agency policy.

4. **Self-Determination**

I will help people receiving supports and services realize their rights and responsibilities, and, as consistent with agency policy, make informed decisions and understand their options related to their physical health and emotional well-being.

5. **Relationships**

I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and consistent with agency policy.

6. **Advocacy**

I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as consistent with agency policy. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. **Personal Health Information and Confidentiality**

I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law, rule, or regulation.

8. **Non-Discrimination**

I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition or disability.

9. **Integrity, Responsibility and Professional Competency**

I will reinforce the values of this organization when it does not compromise the well-being of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. **Reporting Requirement**

As a mandated reporter, I acknowledge my legal obligation under *Social Services Law* § 491, as may be amended from time to time or superseded, to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

_____

CODE OF CONDUCT[1] ACKNOWLEDGMENT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

I pledge to prevent abuse, neglect, or harm toward any person with special needs, consistent with agency policy. In addition, to the extent I am required to report abuse, neglect, or harm of any person with special needs by law, rule, or regulation, I agree to abide by the law, rule, or regulation. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance, notify emergency personnel, including 9-1-1, and inform the management of this organization, consistent with agency policy.

I acknowledge that I have read and that I understand the Code of Conduct.

_____	_____	_____
Signature	Print Name	Date

Program:

Department:

Facility/Provider Organization:

[1] No aspect of this Code of Conduct is in any way intended to interfere, abridge, or infringe upon the rights provided by the *Taylor Law*.

Observer/Intern/Clinical Rotation
Health Assessment Evaluation

BON SECOURS CHARITY HEALTH SYSTEM
A member of the
Westchester Medical Center Health Network

Name:_____ **Date of Birth:** _____

Required Health Documentations:

- PPD Results (within one year), If PPD positive, a Chest X-Ray report must be included
- Rubella Titre
- Rubeola(Measles) Titre, if born after 1/1/57,
- Flu Vaccine administered after November 1st

Do you have a physical, mental, or emotional condition or substance abuse problem that could affect your ability to observe safely?
☐ Yes ☐ No

Do you consider yourself to be in good health? ☐ Yes ☐ No

	Yes	No
Have you ever had a positive PPD (TB skin test)?		
Were you ever placed on medication for having a reaction to the PPD (TB skin test)?		
Have you ever received a BCG vaccine?		

TB AND IMMUNIZATIONS

FOR PPD NEGATIVE REACTORS – Complete the PPD (Mantoux) test information below or submit equivalent form. New York State regulation 405.3 requires PPD (Mantoux) skin test within the last twelve (12) months..

Date administered: _____ Lot #: _____ Left or Right Forearm

Date read: _____ Results: _____mm Induration (Indicate Zero if No Reaction)

Rubella Titer _____
Rubeola(Measles)Titer _____
(if born after 1/1/57)

Signature of Medical Professional (other than yourself):

Signature: _____ Date: _____

Print Name: _____ Office Phone Number:_____

Email:_____

SIGNATURE REQUIRED

I hereby state that the information provided on this form is complete, true and accurate.

Signature: _____ Date: _____

Print Name: _____

Office Use Only – Reviewed By

Signature: _____ Date: _____

Print Name: _____ Employee Health Consult Needed: ☐ Yes ☐ No

Bon Secours Charity Health System

TUBERCULOSIS SCREENING: PPD+ REACTOR QUESTIONNAIRE

CONFIDENTIAL

Name (Print) _____

School: _____

Annual Screening ☐ Post exposure baseline ☐

Post Offer Screening ☐ Post exposure 8-10 wks ☐

During the past 12 months:	YES	NO	IF YES, PLEASE EXPLAIN
Have you been in contact with someone with TB this year?			
If yes, were you wearing a TB mask?			
Has your physician told you that your immune system is weak?			
Have you had a persistent cough this year?			
Have you had a cough lasting greater than 4 weeks?			
Have you had chest pain with the cough?			
Have you had a cough productive of phlegm?			
Have you coughed up blood?			
Has your voice been hoarse most of the year?			
Are you currently a cigarette smoker?			
If not, did you smoke in the past?			
Have you had night sweats?			
Have you had excessive weight loss?			
Have you had a loss of appetite?			
Have you had a persistent fever?			

Student's Signature: _____ Date: _____

Reviewed by: _____ Date: _____