Statement of Agreement

Student and Preceptor

Student Obligations:

I acknowledge and agree that at all times during my clinical rotation at the Hospital I will be under the direct supervision and direction of the St. Joseph Mount Sterling Hospital (Hospital) authorized Medical Staff Appointee(s) and/or APC(s) with Privileges at the Hospital who has agreed to be my Preceptor (Preceptor). I will abide by and comply with all directives given to me by such Preceptor(s) during my clinical rotation at the Hospital.

I have read and agree to comply with all applicable Hospital and Medical Staff policies during my clinical rotation at the Hospital. Such policies were made available to me as part of my clinical rotation orientation.

I understand that I am to consider all information regarding patients as privileged and confidential information in accordance with applicable laws, rules, and regulations, and applicable Hospital/Medical Staff policies. I commit to protecting the privacy of Hospital patients and I will not divulge, release, or share information that is confidential with any other individuals or entities except as permitted or required by applicable laws, rules, and/or regulations, and in accordance with applicable Hospital/Medical Staff policies.

I understand that I must wear a photo identification badge that identifies me as a Student while on Hospital premises.

I attest to the following health status requirements and have provided evidence of the following to the Hospital:

- Negative tuberculin skin test or negative chest x-ray within past year.
- An immunization record of MMR indicating positive history or titer.
- Proof of Hepatitis B vaccine, or documentation of initiation of Hepatitis B vaccine, or a declination/waiver form signed by me.
- Proof of current flu vaccine – during flu season
- Such other immunizations/vaccines as required by applicable Hospital policies.

I have provided Hospital with evidence of my professional liability insurance coverage consistent with applicable requirements.

I have provided the Hospital with the information necessary to complete a criminal background check on me.

I have provided the Hospital with a copy of my current student photo identification card or driver's license for proof of identity.

I have completed or obtained and submitted such other documentation as requested by the Hospital in connection with my clinical rotation at the Hospital. I will promptly notify Hospital of any changes to the information completed or provided during my clinical rotation at Hospital.

I acknowledge that my participation in the clinical rotation at the Hospital may be terminated by the Hospital with or without cause at any time.

Preceptor Obligations:

I understand the expectations regarding the proposed clinical rotation at the Hospital.

I agree to supervise my assigned Student in accordance with applicable laws, rules, regulations, accreditation standards, and Medical Staff and Hospital policies and to be responsible for the Student at all times that the Student is on Hospital premises.

I have read, understand, and agree to comply with the Medical Staff Policy Regarding Educational Opportunities and, as applicable, the CMS *Guidelines for Teaching Physicians, Interns, and Residents*.

I understand and agree to be responsible for apprising the Student of the requirements that the Student must comply with while present on Hospital premises.

The Student will perform all activities under my direct supervision and I will assume full responsibility for the actions of the Student including obtaining consent from the patient prior to the Student's observation of, or participation in, patient care activities at the Hospital.

Student Signature:_____ **Date:**_____

Student Name (printed) _____

Preceptor Signature: _____ **Date:**_____

Preceptor Name (printed) _____