- **Please complete and return the attached packet at least 3 weeks PRIOR to your scheduled rotation at Meadowview Regional Medical Center.**
- **All Physicians <u>MUST</u> sign off on the Sponsoring form before you can attend. This MUST be completed with every new rotation to avoid any conflicts.**
- **If you have any questions please call Kathryn Hutchinson at 606-759-3115.**

Student Checklist:

A. Background-**Level I** Background Investigation (All candidates for employment, volunteers, and students)

1. Social Security Trace
2. Criminal Records Search – County Criminal and/or Statewide Criminal
3. Record Search(es) - *7 years of residential address history or up to 5 criminal searches*
4. National Wants and Warrants Submission
5. US Criminal Records Indicator *(includes a simultaneous search of 50 state sex offender registries and over 200 criminal records*)
6. FACIS – Level I
    a. OIG List of Excluded Individuals/Entities
    b. GSA List of Parties Excluded from Federal Programs
    c. The U.S. Treasury, Office of Foreign Assets Control (OFAC), List of Specially Designated Nationals (SDN)
    d. Applicable State Exclusion List

1. Current urine drug screen- 10 Panel
2. Proof of a PPD x's 2 or QuantiFERON TB Gold
3. Up to date immunization record
4. Security Access Form (SAF)
5. Student MUST attend orientation. Please have student call one month ahead to get the date.
6. Name Badge with photo ID (after orientation)-MUST be returned after rotation

If student packet is incomplete, it will be sent back until completed. You will not be allowed to attend until all forms are completed and signed.

Mission, Vision & Values

LifePoint's facilities and employees across the nation are united by a shared mission and vision and common values.

Our Mission

Making Communities Healthier

Our Vision

We want to create places where:

- People choose to come for healthcare,
- Physicians want to practice, and
- Employees want to work.

Core Values

- Honesty
- Integrity
- Trustworthiness
- Compassion
- Legal/ethical compliance

Our High Five Guiding Principles

LifePoint was founded with five core guiding principles we call our High Five. These principles guide our actions and decision making and define what communities can expect from us as a healthcare partner.

- Delivering high-quality patient care
- Supporting physicians
- Creating excellent workplaces for our employees
- Taking a leadership role in our communities
- Ensuring fiscal responsibility

Meadowview Regional Medical Center
Medical/AHP Student Rotation Policy

POLICY

It is the policy of Meadowview Regional Medical Center to establish and enforce the procedure for Medical/AHP student rotations.

PURPOSE

It is the purpose of this policy to ensure a uniform and standard procedure for medical student rotations in the hospital under physician supervision.

SCOPE

This policy covers all Medical/AHP students during their rotation while at MRMC.

SCOPE OF PRACTICE

Students are not licensed and, therefore, are not legally or ethically permitted to practice. A student may be involved in assisting the care of a patient, but only at the direction and guidance of a licensed physician. Students will have an opportunity to accompany their supervision/sponsoring physician while making hospital rounds, perform history and physicals, participate in patient care, utilize their skills in diagnosis, principles, practice, and treatment and be generally introduced to hospital routine. Students may attend medical staff department meetings related to their rotation service.

RESPONSIBILITIES

It is the MRMC Medical Staff to ensure compliance with the provisions stated within this Policy.

Physicians are responsible for medical care of the patient and for approving and countersigning all history and physicals, order, progress notes, etc. written by the student.

PROCEDURES

The supervision/sponsoring physician will notify Administration when a student rotation is planned.

SPONSORING PHYSICIAN

Name of Student: _____

Dates of Student Rotation: _____

****

Sponsoring Physician's Name: _____

Address: _____

Office Number: _____

Type of Practice: _____

During this student's rotation, it is understood that the student, at all times, will be under my direct guidance and supervision.

_____ _____

Physician's Signature Date

This MUST be completed every new rotation to avoid any conflicts with the Physicians.

Meadowview Regional Medical Center

I hereby certify that the information contained in this information form is true and correct to the best of my knowledge. By signature on this information form, I agree to abide by the policies and procedures governing medical students at Meadowview Regional Medical Center. Specifically, that medical students are allowed to examine patients, review charts and write orders in a patient's chart, but the orders MUST be countersigned by the supervising physician before the orders are carried out. I further agree to abide by all rules, regulations, policies, and procedures of Meadowview Regional Medical Center during my preceptorship at said facility.

_____	_____
Student Signature	Date
_____	_____
Name of Preceptor(s)	Dates of clerkship/rotation
_____	_____
Name of Preceptor(s)	Dates of clerkship/rotation
_____	_____
Name of Preceptor(s)	Dates of clerkship/rotation

TO: CREDENTIALS COMMITTEE
C/O MEADOWVIEW REGIONAL MEDICAL CENTER
989 MEDICAL PARK DRIVE
MAYSVILLE, KY 41056

RE: MENTAL & PHYSICAL COMPETENCE

I have known _____ personal and professionally, and can attest to the fact that the above practitioner is mentally and physically competent to carry out his/her responsibilities for the privileges with which he/she has requested. I therefore recommend his/her appointment/reappointment to the Allied Health Professional staff of Meadowview Regional Medical Center.

_____ _____

Signature Date

_____

Please Print or Type Name & Title

Meadowview Regional Medical Center
989 Medical Park Drive
Maysville, KY 41056
(606) 759-5311

LifePoint IT&S Security Access Form (Facility)

PLEASE COMPLETE ALL HIGHLIGHTED

Student Last Name	Student First Name	MI or "NA"	Status ☐ FT ☐ PT ☐ PRN	Start Date

Work Address	City, State, Zip code	Request Number
989 Medical Park Drive	Maysville, KY 41056	

Phone Number EXT.	Date of birth - - 19	SS# of User - -

User Type ☒ Life Point ☐ Contractor Company name & phone # required for Contractor/Vendor ☐ Vendor **Student**

Exp. Date for STUDENT

Expiration and Approval Requirements — Expiration date must be supplied in field 10 for "Contractors" and "Vendors". The expiration date should be the end of the contract or engagement period.

Department #	Department Name	Job Title
N/A	**Student**	STUDENT

Universal ID	Network login if different from UID	Domain
N/A	Same	LPNT

STUDENT Signature	(19) E-Mail Address	(20) Date
	N/A	

Authorizing Security Coordinator Statement — By signing this request I am stating that I have reviewed the above information for completeness and it is accurate to the best of my knowledge. Also I have reviewed the Information Security Agreement and verified that it has been completely filled out and signed. Also that I verify this request and authorize its processing. **2 signatures required**.

(21) Director/Administrative Rep Signature	**(22)** Security Coordinator Signature	(23) Date

(24) Director/Administrative Rep Printed Name	(25) Security Coordinators Printed Name	(26) Phone Number of HDIS / LSC
		606-759-3234

Applicant has Information Confidentiality & Security Agreement on file ☒ Yes ☐ No

Action: ☒ New ☐ Add ☐ Change ☐ Delete ☐ Terminate Effective Date:

Access Granted By HDIS/LSC	Level	Other Comments
☒ Meditech	Student	Student
☐ Billing System		
☐ Kronos		
☐ NT/AD Account		
☐ Exchange Email	Nickname?	
☐ Remote VPN Connectivity		
☐ Secure ID Card		
☐ VPOM Access	☐ HR ☐ Payroll ☐ General	
☐ FTP Access	☐ HR ☐ Payroll ☐ Budget	
☐ FAS PC Best		
☐ Stars		
☐ TMS		
☐ Medselect		
☐ 3M Coding		
☐ Passport		
☐ HPS System	.....	
☐ PACS		
☐ Accudose		

Comments:

This for serves as documentation for system access necessity for the role of Student

Application	Reason for Access
Meditech	Access is given to allow user to document/edit/view patients record.

Acknowledgment

I acknowledge that I have received LifePoint's' Code of Conduct. I understand that it fosters a culture of learning and safety and that it represents mandatory policies of the organization, and I agree to abide by it.

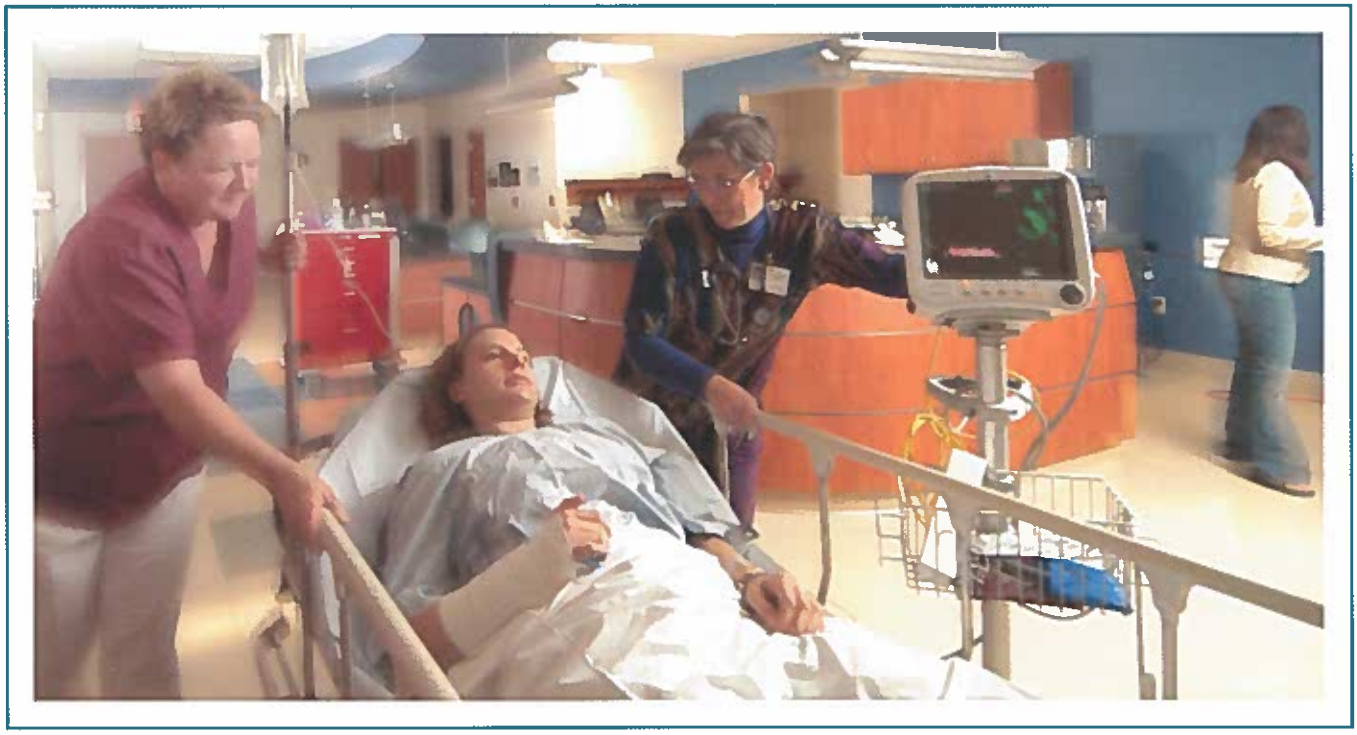
Signature _____

Position _____

Printed Name _____

Date _____

Facility _____



For help with a privacy related concern or to report a complaint or possible violation of the Patient Privacy program, Please contact your supervisor, another member of local management, your local facility privacy officer, the corporate privacy officer, or the corporate ethics line at : **1-877-508-LIFE (5433)**.

P – Protect patient health information (PHI) as if it were your own information.

R – Respect patient requests regarding how their information should be used and disclosed.

I – Inform patients of how you will use and disclose their individually identifiable information.

V – Verify the identity of all persons that may request access to protected health information.

A – Assess access to the minimum necessary amount of information needed to do your job.

C – Comply with the standards for patient Privacy explained in the patient Privacy Program Brochure.

Y – You, are responsible for how you use and disclose patient information- Remember, we care about our patient's and their right to privacy.

HIPAA – Patient Privacy Program

I acknowledge that I have received training for LifePoint Hospital's Patient Privacy Program. I understand that it represents mandatory policies of the organization and my facility, and I agree to abide by it.

Signature

Position

Printed Name

Social Security Number

Date

Facility

Acknowledgement

Confidentiality and Security Agreement

I understand that the facility or business entity named below (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with individually identifiable health information and protected health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will not use company systems to access patient information if it is not necessary to perform my job related duties. This includes NOT accessing my own health information or that of my child or person's for which I am personal representative via the company systems. The Company's Privacy and Security Policies available on the Company intranet (on the Security Page) and the internet (under

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation, even if the patient's name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up electronic media devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
    a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
15. I will never:
    d. Share/disclose user-IDs, passwords or tokens.
    e. Use tools or techniques to break/exploit security measures.
    f. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

The following statements apply to physicians using any Company systems containing patient identifiable health information (e.g. HMS, Meditech, eCW):

17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to m
18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.
19. I have no intention of varying the volume or value of referrals I make to the Company in exchange for Internet access service or for access to any other Company information.
20. I have not agreed, in writing or otherwise, to accept Internet access in exchange for the referral to the Company of any patients or other business.
21. I understand that the Company may decide at any time without notice to no longer provide access to any systems to physicians on the medical staff unless other contracts or agreements state otherwise. I understand that if I am no longer a member of the facility's medical staff, I may no longer use the facility's equipment to access the Internet.

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

Employee/Consultant/Vendor/Office Staff/Physician Signature:	Facility Name and COID Meadowview - 05403	Date:
Employee/Consultant/Vendor/Office Staff/Physician Printed Name:	Business Entity Name Meadowview Regional Medical Center	