Individual Validation of Readiness

(To be kept on file at VH Facility)

Name *(Print)*: _____

Education Experience Type *(Check one)*		Direct Care *(Hands-On)*				Observation or Administrative	
Purpose of educational experience: *(Check one)*		Career exploration		Course requirement		Required hours for *application* to academic program	

School/ Program of Study *(if applicable):*	

Preferred Date(s) or Date Range of Educational Experience:	_____ **to** _____ *Beginning of Rotation Date* *End of Rotation Date*

	Indicate compliance with required documentation by marking with √, *Please note that some elements are **not required** for observational experiences and should be marked NA*									
Name	**Immunization History (Including 2-step TB)**	**Influenza Vaccine (Sept-April)**	**Criminal Background Clearance[1, 2]**	**Urine Drug Screen Clearnace[1, 2]**	**Individual Health and Malpractice Insurance[1,]**	**VH Orientation Module**			
						Certificate of Orientation Completion[2]	**Signed Access &Confidentiality Form[2]**	**Signed Reportable Conditions[2]**	**Signed Student Agreement**
			NOT REQUIRED for Observation						
Check for VH Employee ☐			**Not Required for VH Employee.**			**Completed through VH AMRs** *Validation in LMS*			

1. **EXCEPTIONS for Observation/Administrative Experiences when NO PATIENT CARE is rendered: Exceptions** *refer to the criminal background check, urine drug screen and proof of malpractice insurance. ALL OTHER REQUIREMENTS MUST BE MET.*
2. **VH Employees:** VH Employees undergo the VH Screening process at time of hire as well as annual mandatory education and are therefore considered compliant.

IMPORTANT: After your educational experience, please complete the brief VH online survey of education experience https://www.surveymonkey.com/s/YQR9KNH

Please return this form via pdf copy email or hard copy interdepartmental mail to the Medical Radiography Program **prior to the start of your education experience**. By signing this form, you acknowledge that you completed the necessary requirements and have submitted all documentation to support these requirements. Furthermore, you acknowledge that all education experiences are first cleared through the Medical Radiography Program. VH employees--all mandatories are completed annually.

Signature _____ ***Date***_____

Rev. 2-2015

Student/Faculty/Education Visitor Agreement

I agree that I have requested that I be permitted to participate in an education experience at **Valley Health System** ("Healthcare Facility") in connection with my continuing education at _____ ("Educational Institution"**). If not currently enrolled in an academic program, please mark the blank above with N/A. In consideration of VHS allowing me to participate, I agree to the following terms and conditions.

1. I understand and agree that I will be responsible for all arrangements and expenses (if applicable) related to housing, transportation, uniforms, or meals during education experiences. I agree I will be required to wear clothing meeting the Educational Institution's policy (if applicable) and as required by Healthcare Facility.

2. I understand that I am required to report illness and absence to the Educational Institution (if applicable) and Healthcare Facility. I will maintain health insurance or will assume financial responsibility for any medical treatment for illnesses or injuries I sustain going to or coming from Healthcare Facility, or in connection with my participation in my educational experience.

3. Upon completion of my education experience I will complete any evaluations relating to my education experience using the **VH Non-Employee Online Student Education Evaluation** requested by Healthcare Facility.

4. I will follow the instructions of Healthcare Facility staff (including but not limited to my supervisor) at all times. I agree to follow the instructions of the academic advisor designated by Educational Institution (if applicable). I will comply with policies and procedures governing current practices at Healthcare Facility. These may include, but are not limited to, policies and procedures regarding confidentiality, compliance, quality and risk management, safety, employment, hazardous materials, and universal precautions. I will comply with all applicable federal/state laws and regulations, including but not limited to laws and regulations regarding patient record confidentiality.

5. I acknowledge and agree that Healthcare Facility is not my employer and that, in connection with my educational experience, I will be working as a volunteer at Healthcare Facility without compensation (some exceptions may apply). I further acknowledge and agree that Healthcare Facility will provide no Workers' Compensation insurance or any other employment benefits (including but not limited to health insurance) of any kind to me in connection with my educational experience.

6. If enrolled in an academic program, I acknowledge that my experience will end at such time as I am no longer enrolled at Educational Institution, am no longer in good standing at Educational Institution, or am no longer enrolled in the program for which I have been granted access at Healthcare Facility.

7. I understand that, except for those situations where the law allows a release of information, prior approval from the patient or the surrogate decision maker must be obtained when providing information to anyone other than the persons giving patient care. I agree to comply with all standards of Healthcare Facility relating to patient privacy and confidentiality as applicable to members of Healthcare Facility's workforce. I understand that I may have my authorization for an education experience at Healthcare Facility revoked if I (i) read a patient record without permission; (ii) access the computer for anything other

than approved business purposes; (iii) discuss confidential information with unauthorized persons within or outside Healthcare Facility; (iv) disclose Healthcare Facility financial information without authorization; (v) release information to any news media without authorization; and/or (vi) remove patient records from the Healthcare Facility. I understand and agree that Healthcare Facility may discontinue my education experience at any time, including, without limitation, circumstances in which I violate the terms of this Agreement.

8. I agree that I am not permitted, under any circumstances, to copy or otherwise take from Healthcare Facility individually identifiable health information (as defined under 45 C.F.R. Section 160.103). I understand that I may be permitted to take notes from patient records and patient interactions as long as the following conditions are met:

(i) The notes are required for my course of instruction;

(ii) The notes do not contain any individually identifiable health information; and,

(iii) Permission is obtained from my supervisor.

9. I further agree to execute any agreements that may be required pursuant to the HIPAA Privacy Regulations, and any confidentiality statements that may be required by Healthcare Facility. I understand that this Agreement is enforceable by Healthcare Facility.

Signed: _____Date:_____
Student/Faculty/Education Visitor Signature

Printed Name_____

***For students enrolled in academic programs and faculty, Educational Institutions are to keep signed copies of required VH documentation on file with supporting documentation available for review by Healthcare Facility upon request.*

ValleyHealth

Student/Adjunct Faculty/Education Visitors
Pre-Rotation Immunization Requirements Documentation
OBSERVATION/SHADOWING

School Name_____Student/Faculty/Visitor Name_____

Date of Birth _____SS# or Student ID Number_____

The following immunization guidelines are solely intended for Observation Students in a VHS facility. The Observation Student will not perform direct/ hands-on patient care nor be alone with patients.

1. **Influenza Vaccine:** Annual flu vaccination mandatory for students, faculty, and education visitor during flu season September through April.
   Document date Flu Vaccine _____

2. **Tuberculosis Skin Test (TST)** -- **None required if student is enrolled in a public school K-12**
   - **Enrolled in public school Yes ____ No ____**
   - **If No -- must have proof of a NEGATIVE TST** **date_____**
     or a NEGATIVE Chest XRAY within the past 6 months **date_____**

3. **Measles, Mumps & Rubella** ***(Required to provide 2 dates of MMR vaccination or date of disease.)***
   - **Vaccine: MMR # 1 date_____ MMR # 2 date_____**

   OR
   - **Disease date: Measles date _____Mumps date_____ Rubella date _____**

4. **Varicella (Chickenpox)** ***(Required to provide 2 dates of Varicella vaccination or date of disease.)***
   - **Vaccine: Varicella #1 date _____ Varicella #2 date _____**

   OR
   - **Disease date: Chickenpox date _____**

5. **Tdap* (Tetanus, diphtheria, pertussis) --**

Required only if observing in High Risk area, defined as an area with patients age 12 or younger.

- **Tdap vaccine date _____ Observation Area _____**

Please read: In the unlikely event that the above named Observation Student is listed on an infection control exposure list, the EOHS nurse will immediately notify the Medical Radiography Program to notify the student. The student will be advised to seek appropriate care via his school health program or personal healthcare provider.
I agree ……

- should I be required to obtain additional vaccine(s), or lab work, in order to meet the *Observation Student* requirements, I will obtain at my own expense.
- I understand I am being cleared as an observer only and agree not to have any direct patient contact nor interact individually with any patient.
- the above immunization information is an accurate report of my immunization history.

Name Printed_____Signature_____ Date _____

This document will be reviewed for clearance, by the Radiography Program, prior to the start of student observation.

Rev 3-1-2015

NOTICE OF REPORTABLE CONDITIONS
Student/Faculty/Education Visitor

PLEASE PRINT:

Name:_____ Date:_____

Social Security Number:_____

Educational Institution:_____ Program:_____

In compliance with Valley Health System's ("VH") established policies governing employee/student health, you are required to report the following conditions to your Educational Institution prior to performing clinical rotations:

1. Acute diarrheal illness (severe) with other symptoms (i.e., fever, abdominal cramps, bleeding, etc), or diarrhea lasting longer than 24 hours.
2. Orofacial herpes simplex virus or herpetic whitlow.
3. Diagnosed streptococcal infection.
4. Skin lesions that are infected & draining, especially on exposed body parts.
5. Acute upper respiratory (URI) or severe influenza with a temperature above 100', purulent sputum.
6. Active infection with/or exposure to:
   a. Hepatitis (jaundice).
   b. Human immunodeficiency virus (HIV).
   c. Measles (if you are not immune)
   d. Mumps (if you are not immune)
   e. Rubella (if you are not immune)
   f. Varicella Zoster (chicken pox/shingles) virus (if you are not immune.
   g. Tuberculosis
   h. Conjunctivitis (pink eye)
   i. Any communicable disease if student is unsure of immunity.
7. Needle stick/sharps accident, parenteral/mucous membrane or nonintact skin exposure to patient's blood or body fluids containing visible blood.
8. Diagnosed with a positive culture, which prevents or limits my ability to render patient care, I understand I will be referred to a physician of Valley Health's choice or a physician who will agree to follow the medical protocols recommended by the Infection Control Physician Director of this facility.

I understand that it is my responsibility to notify my Educational Institution of any potential that I may have of infection with an infectious disease and I agree to notify my Educational Institution immediately if I have or experience any of the conditions/events referenced above. I understand that this notification is to protect myself, patients, and other staff/student members. I agree that Educational Institution may disclose, to employees of VH, my information regarding any potential infection and any condition/event referenced above, and my test result relating to any reportable, communicable condition, as outlined in the Virginia Department of Health Regulations for Disease Reporting and Control. I understand and agree that if the VH Infection Control Department becomes aware of any such information, VH Infection Control may notify my Educational Institution.

I certify that this document has been explained to me and that I understand its contents. I certify that a copy of this document has been provided to me and a copy will be placed in my Student file at my Educational Institution.

_____ _____

Date Signature – Student

If you have any questions pertaining to any of the above conditions please contact your Educational Institution's Health Service.

Rev 2-1-2013

Student, Faculty and Education Visitor Orientation Checklist

Name_____

School _____Date _____

The student, faculty, or visitor listed above has completed the VH Non-Employee Online Orientation which includes the following topics required by accrediting agencies and to maintain safe environments of care:

- Valley Health Vision & Mission Statements
- Valley Health Values
- Code of Ethics
- Language of Caring
- Performance Improvement Through Lean
- Cultural Diversity
- Sensitivity: Bariatric Surgery Caring for the Obese Person
- Human Resources
- Compliance/HIPPA
- Safety/Security
- Process Improvement – Patient Safety, Risk Management
- Infection Control
- Back Injury

For individual students NOT enrolled in a health professions program, please submit with complete packet of required VHS documentation.

For students enrolled in a health professions program, please give this completed form to your academic institution contact

ACCESS AND CONFIDENTIALITY AGREEMENT

As a student, faculty, or education visitor of Valley Health ("VH"), I may have access to what this agreement refers to as "confidential information". Confidential information includes, but is not limited to, individually identifiable information concerning patients, families, employees, volunteers, and physicians. It may also include financial information and other information relating to VH. I may learn of or have access to some or all of this confidential information through a computer system or through my education activities.

Confidential information is valuable and sensitive and is protected by federal and state laws and regulations as well as strict VH policies. As a student, faculty, or education visitor of VH, I understand that I must comply with these laws and policies governing confidential information. I also understand that the violation of these laws and policies will subject me to discipline, which might include but is not limited to termination of education rotation, and to potential legal liability.

Accordingly, as a condition of an in consideration of my access to confidential information, I agree and promise that:

1. I will use confidential information only as needed to perform my legitimate duties as a student, faculty, or education visitor of Valley Health.

This means, among other things, that:

A. I will only access confidential information for which I have a need to know; and
B. I will only disclose confidential information to employees, volunteers, physicians, and other persons who have a right and need to know; and
C. I will only access and disclose confidential information in a manner which provides for privacy and security; and
D. I will not in any way divulge, copy, release, sell, loan, review, alter or destroy any confidential information except as properly authorized within the scope of my legitimate duties; and
E. I will not misuse confidential information or carelessly care for confidential information.

2. I will safeguard and will not disclose my personal information, identification badge, or any other authorization I have that allows me to access confidential information. In addition, I will accept responsibility for all activities undertaken using my identification badge, or other authorization.

3. I understand that my obligations under this Agreement will continue after I complete the education experience at VH. I also understand that my privileges hereunder are subject to periodic review, and that VH may at any time revoke my access to confidential information.

4. I understand that this Access and Confidentiality Agreement is identical with HR Policy 504, "Confidentiality". I understand that my education experience is contingent upon my adherence to the information stated above and my adherence to this policy. I further understand that my failure to comply with this Agreement or applicable laws and policies may result in discontinuation of my education experience at VH.

5. I understand that I have the right to report directly to The Joint Commission on Accreditation of Healthcare Organization, without fear of any disciplinary action or retaliation, any concerns about confidentiality and/or the quality and safety of care provided to patients by Valley Health.

Employee Signature:_____

Printed Name:_____

INTEGRITY HOTLINE
1-800-492-5646

Valley Health has established a toll free Integrity Hotline available to all members of the Valley Health team. Any employee, physician, student, faculty or education visitor, may call the Integrity Hotline to ask questions concerning ethical or legal conduct or to report concerns anonymously. All reports are confidential and the staff of the Integrity Hotline will address all reasonable questions and concerns. Calls to the Integrity Hotline are not traced or recorded (unless the caller chooses to leave a message) and no caller will be subject to retaliation or reprisal for expressing his or her concerns in good faith.

The Integrity Hotline is not intended to replace the established communication channels, such as talking with a supervisory staff member, but provides an additional method of communicating when the caller is uncomfortable using other channels or needs additional assistance.

The Integrity Hotline is answered explaining our policy on the anonymity of the caller. All reports are anonymous through The Network's call center, which is staffed 24/7/365 with trained experts, or online using The Network's website. To report concerns online, go to reportlineweb.com/ValleyHealthLink
Voice mail will be available if you choose to leave a message.

Use The Network to report concerns about any inappropriate or unethical behavior or activity throughout Valley Health. Examples of reportable issues include:
Patient Care & Safety, Patient Privacy & Confidentiality, Abuse of Company Property, Accounting/Audit Irregularities, Billing Compliance, Conflicts of Interest, Discrimination or Harassment, Fraud, Human Resource Policy Violations, Inappropriate Behavior, Management Issues, Policy Violations, Retaliation, Safety & Environmental Issues,
Substance Abuse, Theft of Goods or Services, Violation of STARS Values, Visitor Safety, Workplace Violence and Threats, Any other concerns about unethical or inappropriate activities.

VALLEY HEALTH CODE OF ETHICS

I have received and have read a copy of the Valley Health Code of Ethics and I agree to abide by the integrity guidelines set forth in Valley Health Code of Ethics.

_____ _____

Student/Faculty/Education Visitor Name Date