Trios™ Health

MEDICAL STUDENT AUDITION ROTATION APPLICATION

MEDICAL STUDENT INFORMATION

Full Name (including middle) _____ Male ____ Female ____

Date of Birth _____ Year in Medical School _____

Rotation Requested _____ Rotation Dates Requested _____

Physician Supervisor (Completed by Trios Staff) _____

MEDICAL SCHOOL ADDRESS		HOME ADDRESS	
School Name		Street	
Street		City, State, Zip	
City, State, Zip		Hm Phone #	
School Contact Name		Cell Phone #	
Contact Phone #		Your Email	
Contact Fax#			
Contact Email			

MALPRACTICE COVERAGE

Name of Carrier: Insured Name on Policy:	Policy #: Coverage Amt:

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of rotation at Trios Health.

I hereby request a medical student, audition rotation at Trios Health. I attest that my training and experience qualifies me to perform the clinical activities that I have requested and I agree to abide by the Medical Staff and Hospital Bylaws, Rules and Regulations and Policies.

_____ _____ _____

Signature of Applicant **Printed Name** **Date**

_____ _____ _____

Signature of Physician Sponsor **Printed Name** **Date**

Trios™ Health

AUTHORIZATION FOR RELEASE OF INFORMATION

I HEREBY APPLY FOR A MEDICAL STUDENT ROTATION AT Trios Health:

I understand that the Education Services Department of Trios Health is responsible for the evaluation of my professional competence and qualifications, and has the obligation to inquire into my professional training, experience, professional conduct and judgment, and to make appropriate recommendations to the Hospital Board of Trustees.

In making this application for Medical Student Rotation to the Education Services Department, I acknowledge that I am familiar with the principles and standards of the Joint Commission and the principles, standards, and ethics of the national, state, and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof, and I further agree to abide by such Staff Bylaws, Rules & Regulations and Medical Staff policies as well as Hospital policies as may be from time to time enacted.

Evaluation and inquiries into my professional competence and qualifications shall be accomplished in a professional manner. I shall be afforded due process in the event that action on this application, or with respect to my privileges, is adverse. Such procedure shall include reasonable notice of the reasons for such action, and opportunity for rebuttal and impartial determination, as is more specifically set forth in the Bylaws.

I hereby release from liability all representatives of Trios Health and its Medical Staff for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to Trios Health or its Medical Staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff reappointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information by Trios Health or its Medical Staff, to other hospitals, medical associations and other interested persons, on my properly authorized written request regarding any information the Hospital and the Medical Staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability this Hospital and its staff for so doing.

I understand and agree that I, as an applicant for Medical Student Rotation, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I certify that I am physically and mentally able to perform the clinical activities that I have requested at Trios Health.

I fully understand that any significant misstatements in or omissions from this application constitute cause for denial of my Medical Student Rotation application. All information submitted by me in this application is true to my best knowledge and belief.

This statement shall remain in effect as long as I am a Medical Student at Trios Health unless revoked by me personally.

Signature: _____ **Date:** _____

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MEDICAL STUDENT ROTATION SCOPE OF PRACTICE

Medical Student Name (Print): _____

All Medical Student patient/clinical activities will be performed under the direct supervision of a Sponsoring Physician with appropriate credentials and privileges at Trios Health.

No Medical Staff membership or privileges are granted for Medical Student activities at Trios Health.

General Clinical Activities:

- Interview Patient
- History and Physical
- Access Electronic Medical Record (Practice Partner)
- Participate in Minor Procedures (OR, ED, etc.) under direct supervision of physician sponsor

Student Signature: _____ **Date:** _____

Send Completed Information to:

Education Services at Trios Health

Fax: 509-221-5718
Mail: Trios Health/Education Services
900 S. Auburn Street
Kennewick, WA 99336

Trios™ Health

STUDENT SUBSTANCE ABUSE AGREEMENT

Students will not routinely be screened for substance abuse before clinical experiences at Kennewick Public Hospital District [KPHD]/Trios Health. However, if a student displays behavior that may indicate possible substance abuse, the student will be asked to undergo testing. This testing could involve one of the following: blood testing, urine screening or Breathalyzer. The student must comply with this request immediately. Failure to do so will be reported to the agency sponsoring the student and that individual will be removed from their experience. The costs incurred for such testing will be the responsibility of KPHD and the results will be shared with the sponsoring agency.

I acknowledge and understand this substance abuse agreement.

_____

Student Signature Date

_____

Witness Signature Date

Trios™ Health

CONFIDENTIALITY STATEMENT

(This document is not intended to be signed by individuals/entities subject to a Business Associate Agreement; nor is this document necessary for those individuals/entities providing treatment to the patient, e.g., specialists. Rather, this document shall be used to document your efforts to reasonably safeguard PHI for those individuals/entities that may have "incidental" access to PHI, e.g., a janitorial service that is contracted to clean the practice/health care facility.) 45 CFR s. 164.530 (c)(2)(ii)

All patient Protected Health Information (PHI—which includes patient medical and financial information), employee records, financial and operating data of Kennewick Public Hospital District, and any other information of a private or sensitive nature is considered confidential. Confidential information shall not be used or disclosed unless specific permission to do so has been obtained and granted by the privacy officer or designee. Applicable federal and state laws shall be followed to seek patient permission for any use or disclosure of PHI. Examples of inappropriate disclosures include:

- Discussing or revealing confidential information to friends or family members.
- Discussing or revealing confidential information to other coworkers or employees without a legitimate need to know.
- The disclosure of a patient's presence in the office, hospital, or other medical facility, without the patient's consent, to an unauthorized party without a legitimate need to know and that may indicate the nature of the illness and jeopardize confidentiality.
- Using patient information for marketing purposes without express permission from the Kennewick Public Hospital District and patient.

The unauthorized disclosure of confidential information can subject an individual and the individual's employer to liability. Disclosure of confidential information to unauthorized persons, or unauthorized access to, or misuse, theft, destruction, alteration, or sabotage of such information, may result in your immediate removal from the premises and/or revocation of current and future visiting/working privileges of the individual and/or company, and may lead to legal action and/or a duty for you to mitigate damages.

Confidentiality Agreement

I hereby acknowledge, by my signature below, that I understand that patient PHI and other confidential or proprietary information of Kennewick Public Hospital District which I may see or hear or otherwise gain knowledge of in the course of my visit/work with Kennewick Public Hospital District is to be kept confidential, and this confidentiality is a condition of my privilege to visit/work with Kennewick Public Hospital District. This information shall not be used or disclosed to anyone unless specifically authorized by Kennewick Public Hospital District. The unauthorized use or disclosure of patient PHI is possible grounds for: immediate removal from the premises; revocation of all future visiting/working privileges; legal action; and/or a duty to mitigate damages.

Signature_____ Date _____Dept. _____

_____

(Please PRINT name clearly)

Trios™ Health

SYSTEMS ACCESS SECURITY AGREEMENT FOR STUDENTS ACCESS

Education Department: Please completely fill out all of the following information. This document must be reviewed with the student by a Trios Health designated staff person providing education or system access information to students.

Please print legibly

Student Information	Student Last Name	Student First Name	Student MI
Student Information	Student DOB	Student email	
Education Facility Select One	___CBC ___WSU-TC _____List Other		
Student Phone Number			
Reason for access	Clinical Rotation at Trios Health		
Clinical Rotation Start Date	**Completed by Education Department when rotation is approved*		
Clinical Rotation End Date	**Completed by Education Department when rotation is approved*		
Additional Notes:			

I hereby request remote access to the Kennewick Public Hospital District (KPHD) and Trios Health network & systems. By signing this document, I agree to comply with the following rules:

1. Under no circumstance will I allow another person to access KPHD & Trios Health Information Systems through the use or disclosure of the Sign-on/Password which I have received, nor will I attempt to use another person's Sign-on/Password.

2. Under no circumstance will I attempt to gain access to any portion of KPHD & Trios Health information systems that are not pertinent to the fulfillment of my student responsibilities.

3. Upon termination of my clinical rotation with listed education facility, or student privileges with KPHD & Trios Health, I will not attempt to use the Sign-on/Password that have been issued to me.

I understand that any breach of these rules may be grounds for disciplinary action up to and including termination of access to these information systems or termination of clinical practicum rotation.

_____

_____

Student Signature *Date* *Trios Health Educator Signature* *Date*