STUDENT EXPERIENCE APPLICATION

AULTMAN ALLIANCE COMMUNITY HOSPITAL

AULTMAN ALLIANCE COMMUNITY HOSPITAL
OFFICE USE ONLY

Program Coordinator (PC):
___Affiliation Agreement current with College/University: _____
___Copy of Criminal Background Check (current within 12 months)
___Copy of current 2-step TB Results and/or with a copy of each year after the 2-step
___Health Questionnaire
___Safety/Competency Quiz
___Information & Policy Acknowledgement Form
___Department Assigned:_____ Instructor: _____
___Duration- Start Date: _____ End Date: _____
___Total Hours Requested: _____Total Hours Completed: _____
___Badge Request Form sent to CR department. *($10.00 exact cash required prior to printing)*
___New Student Orientation Checklist

Signing below indicates that you confirm that the student intern has successfully submitted all requirements; received proper training and orientation; and that student has possession of Student Information Packet.

Signature: _____ Date: _____

Section I: Personal Data
(Please Print Clearly)

Full Name: _____ Date: _____

Email Address: _____ Date of Birth: _____

Street Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ SSN: ###-##-_____

Emergency Contacts:
Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

If you have lived outside of Ohio in the last (10) ten years, please list additional address(es):
Street Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Street Address: _____ Apt: _____
City: _____ State: _____ Zip Code: _____
Have you ever been convicted of a crime other than a minor traffic offense? □Yes □No
If yes, please explain: _____

Section II: Interests and Availability
(Please Print Clearly)

Please briefly describe your ideal internship: _____

_____

_____

Area or Department of Interest: _____

Is this a college requirement? □Yes □No If yes, what college: _____

Number of Hours Needed: _____ Dates of Observation Requested: _____

Name of College Program Advisor or Instructor: _____
Phone: _____ Email: _____

Section III: Student Agreement
(Please Read and Sign)

Statement of Equal Opportunity in the Student Experience Program: Aultman Alliance Community Hospital is dedicated to the Planetree philosophy of healing mind, body and spirit. The organization's mission is to provide our patients and guests with a safe, comforting, healing environment and is achieved through our philosophy of patient-centered care and use of integrative therapies in conjunction with leading-edge technology. Students will be recruited and placed in volunteer positions without regard to race, color, religion, age, sex, national origin, disability or handicap, except where age, sex, or physical handicap is a bona fide assignment qualification. Decisions on student placement will be based solely upon an individual's qualifications, interests, availability and Aultman Alliance Community Hospital needs. *As part of this decision making process, a background check may be conducted on each applicant. This check will be conducted by the designated school representative or at the student's own cost and the results will be kept confidential. Results are to be mailed to corresponding AACH representative.

- I agree to keep **confidential** all information about patients, staff and physicians that I may become aware of while carrying out my student assignment. I agree to keep all information I may encounter while at Aultman Alliance Community Hospital completely **confidential. Information that must be confidential includes identity (name, personal information), physical or psychological condition, emotional status, conversation between patient and healthcare providers, and paperwork on or about a person.** I understand that falsification of information on this application, failure to maintain strict confidentiality, or any violations of the policies outlined by the department manager may result in my immediate dismissal from the work area and/or serious legal consequences.
- **All information** included in this application form is **correct** to the best of my knowledge.
- I further understand that **falsification** of information on this application or violation of the policies outlined in the volunteer handbook may result in my immediate dismissal from the program.

Applicant Signature: _____ Date: _____

Section IV: Student Paperwork
(Please complete each item and return with application)

- ☐ **Safety/Competency Quiz**: *Read the Student Information Packet and complete the open book quiz.*
- ☐ **Information and Policy Acknowledgement Form**: *Read all of the policies and information management items found in the Student Information Packet and verify your understanding by signing off on each.*
- ☐ **Criminal Background Check:** *State of Ohio BCI&I background check is required and must have been completed in the last twelve (12) months from date of anticipated start date with Alliance Community Hospital. If student has lived outside of Ohio in the last five (5) years, then an FBI background check is also required. Completed at student's own expense. Copies of actual reports are required.*
- ☐ **TB (PPD-Mantoux) Test**: *All student interns need to complete a 2-step TB test. If you have had a 2-step TB test (or have proof of a 2-step followed by an annual 1-step testing *note: blood assay tests do not require additional testing) within the last (6) six months then you may provide a copy of your results. Completed at student's own expense. Copies of report with test dates and results are required.*
- ☐ **Health History Questionnaire:** *Immunization Records verification (including but not limited to MMR (Measles, Mumps, and Rubella), Varicella, Tetanus/T-dap, and the Hepatitis B series.*
- ☐ **Influenza Vaccination**: *All students will be offered the influenza vaccine during flu season (early October – late March) and documentation will be kept to track the acceptance or declination of the vaccine. This can be done during the Colleague Tune-Up in October.*

Section V: Upon Acceptance
(Please abide by this information)

- ☐ **Dress Attire**: *All students will ensure that their clothing projects a neat, clean appearance; comfortable closed-toe shoes; no excessive jewelry, perfume/cologne; good body, hair and oral hygiene is required. No shorts, short skirts, facial piercings, low-cut tops or jeans are to be worn with the exception of Foundation Fridays in which certain departments may wear jeans for a $5.00 donation to the AACH Foundation.*
- ☐ **Identification Badges**: *students are required to wear identification while at AACH and will be provided a* ***photo identification badge at a charge of $10.00****. A badge request form will need to be completed and the program coordinator will escort student to receive identification badge or provide a general student badge.*
- ☐ **Resignation**: *Students are to notify the Aultman Alliance Community Hospital Program Coordinator and your assigned Department of your resignation date/completion of your internship or assignment.*

Please return your identification badge to the Program Coordinator, in person, upon your resignation.

AULTMAN ALLIANCE COMMUNITY HOSPITAL
STUDENT PROGRAM
Safety/Competency Quiz

Full Name: _____ Date: _____

This quiz covers the following materials found in the student information packet: Corporate Compliance, Confidentiality, Quality, Patient Rights and Responsibilities, Information Management, Summary of Emergency Codes, Personal/Fire/Electrical Safety, Isolation and Infection Control, Hazardous Materials and SDS, Ethics, Patient Safety and Abuse, White Rose, Impaired Practitioner, Resident Rights, Regulatory Agencies, and Restraints.

Circle your answer, either True or False. Minimum Score Required: 22/25

1. **True or False:** AACH has a corporate compliance program with reporting services available 24 hours a day, seven days a week to report any violations of policies and procedures.
2. **True or False:** Students don't need to uphold the code of ethics or keep things confidential at the hospital.
3. **True or False:** Quality means doing the right thing right the first time with the goal of providing the best care.
4. **True or False:** Data and information processed in the information systems are proprietary and confidential.
5. **True or False:** At AACH, patients have the right to exercise their rights without coercion, discrimination, or retaliation.
6. **True or False**: Patients have the right to personal privacy, to receive care in a safe setting, to be free from all forms of abuse or harassment, and to confidentiality of their clinical records.
7. **True or False**: To activate a code or in situations of emergency you should dial 5555.
8. **True or False:** During a Phase II Code Gray, a tornado has been spotted within a 10 mile radius of hospital and all patient are to be covered with blankets/sheets with staff lying/crouching down and covering their heads.
9. **True or False:** Partial and Hospital Wide are the two types of Code Green: Evacuation.
10. **True or False:** The Class of fire that healthcare settings are least likely to experience is a Class D fire.
11. **True or False:** The "A" in the fire safety acronym RACE stands for "aim the nozzle at the base of the fire".
12. **True or False:** When we assume that everyone has potentially infectious blood and body fluids, we are following standard precautions.
13. **True or False:** When there is presence of C-diff or hands are visibly soiled it's okay to use alcohol sanitizers.
14. **True or False:** Biohazard waste has special precautions for disposing of it, including the use of red bags.
15. **True or False:** The two key ways to protect yourself and others from possible TB exposure include early identification and by avoiding all contact with people.
16. **True or False:** Ingestion, absorption, inhalation and injection are the four common ways for chemicals to enter the body.
17. **True or False:** As a healthcare worker you may need to use SDS (safety data sheet) for your own safety when working with chemicals.
18. **True or False:** All patients are assessed for risk or abuse but every colleague needs to be aware of signs and signals of abuse.
19. **True or False:** When there's a white rose magnet on a patient's door it's okay to be loud near that room.
20. **True or False:** The Impaired Practitioner Policy defines physician impairment and addresses the procedure for how to handle any concerns in relation this.
21. **True or False:** Three major problems that could lead to physician impairment include substance abuse, psychological problems and physical illness.
22. **True or False:** If any individual working at AACH has a suspicion the first step they should take would be to write a report and give it to an executive officer for further investigation.
23. **True or False:** As a resident of the Community Care Center, a resident should not be treated with courtesy and respect in full recognition or dignity and individuality.
24. **True or False:** Notice of a proposed transfer or discharge shall be in accordance with the Community Care Center's resident rights for each resident of a home.
25. **True or False:** A restraint is any method, physical or mechanical device, material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely.

Student's Score: _____ Passing: Yes☐ No☐ Date:_____

AULTMAN ALLIANCE COMMUNITY HOSPITAL

STUDENT PROGRAM

INFORMATION MANAGEMENT & POLICY ACKNOWLEDGEMENT

Full Name: _____ Date: _____

By signing off on each policy and information listed below, as found in the Student Information Packet; you are acknowledging that you have fully read and understand each item and your role in abiding by each. You must sign and date at each line.

Policy / Information Title	**Signature**	**Date**
Corporate Compliance	_____	
Confidentiality / HIPAA	_____	
Sexual Harassment Policy	_____	
Tobacco Free Policy	_____	
Cell Phone Policy	_____	
Computer & Network Access Policy	_____	
Summary of Emergency Codes	_____	
Planetree & Healthcare Expectations	_____	
Community Care Resident Rights	_____	
Regulatory Agencies & Resident Advocates	_____	

Return this form to Program Coordinator with Completed Student Application; please keep the Student Information Packet as to reference materials when needed.

Program Coordinator Name: _____

Received on Date: _____

AULTMAN ALLIANCE COMMUNITY HOSPITAL
STUDENT EXPERIENCE
HEALTH HISTORY QUESTIONNAIRE

If you have a copy of your immunization record please submit a copy

Today's Date: _____

Full Name: _____ DOB: ___/____/_____

School/Program: _____Phone Number: _____

Family Physician Name: _____ Facility: _____

Immunization Record Verification:

1. Have you received a 2-step TB Test?

   □Yes Dates: _____

2. Have you received any MMR Vaccinations?

   □ Yes Date: _____ □ No

   Do you have a history of (please check):

   Mumps: □Yes □No □Titer date _____

   Rubella: □ Yes □No □Titer date _____

   Measles □ Yes □No □Titer date _____

4. Have you had the chicken pox (varicella) disease or vaccine?

   □ Yes □No □ Titer date _____

5. Have you had the Hepatitis B Vaccine series?

   □ Yes (Date) _____ □ No □Titer date _____

6. Have you had a Td/T-dap vaccine within the last ten years?`

   □Yes (Date) _____ □ No

7. If flu season (early October – late March): Have you had the influenza vaccination?

   □ Yes; Date_____ □ No

Influenza Notice: The Advisory Committee on Immunization Practices(ACIP) and Centers for Disease Control and prevention(CDC) recommends routine annual influenza vaccination of all persons 6 months and older.

I hereby declare that, to the best of my knowledge and belief, the particular given is true.

Individual's Printed Name _____ Date_____

Individual's Signature _____

Exhibit C

Student Printed Name: _____ Date: _____

Affiliate Name: _____

STUDENT ACKNOWLEDGMENT

I, the Student, do hereby acknowledge that I have read and understand the following statements. I agree to abide by and be bound by the following statements in return for Aultman Alliance Community Hospital allowing me to participate in an educational experience on its premises.

1. I will conduct my educational activities at Aultman Alliance Community Hospital ("Hospital") only under the supervision of a Hospital employee, medical staff member, or affiliated faculty member.

2. I will comply with all Hospital rules, regulations, policies and procedures.

3. I understand that Hospital retains the right to remove any student at any time in its sole discretion and that I will receive no due process rights prior to such decision by Hospital.

4. I acknowledge that I am not an employee of Hospital and that I will receive no compensation or benefits for participation at Hospital.

5. I understand that I am responsible for the cost of any medical care that I receive from Hospital for any reason, and the costs of travel, meal expenses, identification badge and dress attire.

6. I understand that I may be required to attend and/or complete orientation programs, including but not limited to, confidentiality, fire, safety and area specific requirements. When required, I will attend such orientations prior to beginning assignment at Hospital.

7. I understand that all patient information, protected health information (PHI), medical records, and all Hospital business, employment and financial information is confidential. I acknowledge my responsibility and liability regarding the confidential nature of all information that I have access to at Hospital by virtue of my participation in this program. I understand my responsibilities with respect to patient information.

8. I will protect all confidential information and will not disclose any confidential information unless permitted by Hospital or Hospital policies.

9. Any educational work product (e.g., reports) pertaining to my experience at Hospital will not contain confidential information. Upon Hospital's request, I will submit a copy of any educational work product to Hospital for review prior to publication or disclosure.

Signature: _____ Date: _____

Term of Educational Experience: _____ to _____

AULTMAN ALLIANCE COMMUNITY HOSPITAL
STUDENT EXPERIENCE
NEW STUDENT ORIENTATION CHECKLIST
To be completed the first day

Student Full Name: _____ Start Date: _____
Department: _____ Instructor/ Designee: _____

Each item should be checked off on the line provided before returning to assigned Program Coordinator. The orientation must be completed by Department Instructor or Designated person. The orientation of new students is very important and should be carried on conscientiously. Every effort should be made to make them feel comfortable and welcome.

Procedure:
This checklist should be completed, signed by those involved and returned to Program Coordinator by the end of the first day.

_____ Review parking map and parking procedures. (Map attached on page 9)
_____ Introduction to Department rules and policies; inform them where they can find policies of department.

_____ Tour of Department - introduce student to colleagues and department managers/supervisors, briefly explaining the work they do. Introduce to colleagues in other departments where appropriate.

_____ Information regarding facilities – restroom location, work supplies, bulletin boards, and cafeteria.

_____ Student is aware of central location of manager business cards with administrator information on back to pass out to customers and patients.

_____ Review and discuss goals, schedule, hours of work and lunch provisions - time and place.

_____ Review the importance of good attendance, calling in to college clinical instructor and/or AACH program coordinator, etc. Poor, unreliable attendance may lead to dismissal from student experience program.

_____ Telephone courtesy, personal and emergency calls (5555), cell phone policy (found within student packet).

_____ Review confidential information, students/colleagues should not discuss patient/customer information or any confidential information with co-workers, friends, relatives, or strangers.

_____ Safety – alert student to hazards associated with their work area and procedure to follow in event of accident or fire.

_____ Equipment – discuss care and proper usage of any equipment colleague will use on the job. Demonstrate proper use and observe student using equipment.

_____ Review disaster plan procedure and Bomb Threat procedure for department, and location of disaster manual.

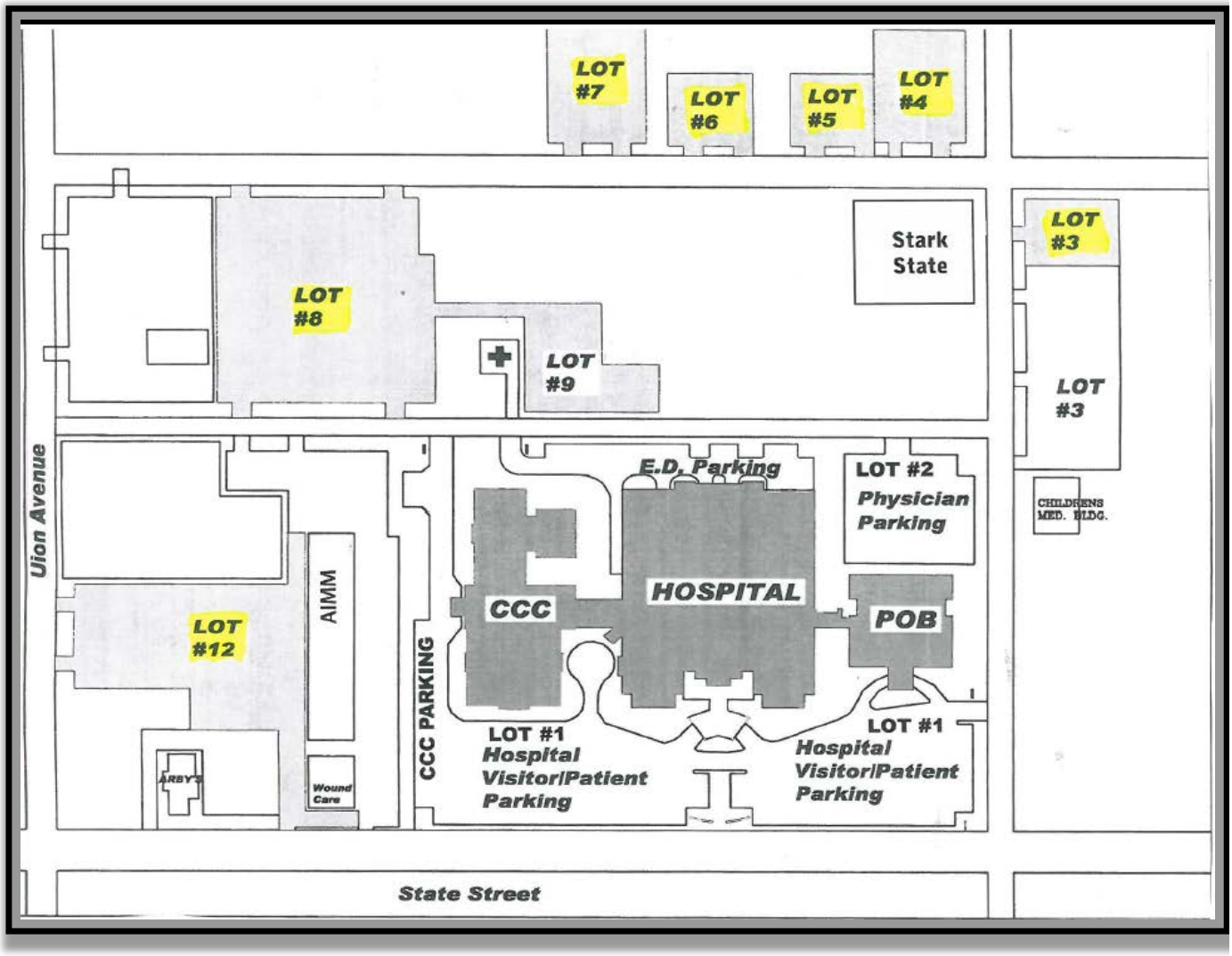
_____ Unit Specific Core Measures/QAPI – Implementation, Documentation, Outcome.

_____ Completely answer any remaining questions, ensure they have managers/directors contact information and assigned Program Coordinator's contact information.

Student: _____ Date: _____
Department Instructor/Designee: _____ Date: _____

Exhibit D

Parking Map/Instructions



All Students are to park in lot numbers 3, 4, 5,6,7,8 and 12. When using lot # 12, please park past row 6 due to patient parking being in the front rows. Additionally, no one should be parking in the spaces allocated to Akron Children's Clinic in lot 3.