Instructions for Student Onboarding

Directions:

1. Review **Student Experience Policy** and **Orientation Material** in the reading packet on our Student Portal site.

2. Complete and sign the following documents (all in paperwork packet)
    1. **Orientation Checklist**
    2. **Post Test**
    3. **Student Profile**
    4. **Acceptable Use Agreement Form**
    5. **Confidentiality/Nondisclosure Form**
    6. **Immunization Verification Form**
    7. **Student Clinical Inquiry Projects Form** (if applicable)

3. Submit badge photo (see instruction sheet)

Please submit to the Student Program Coordinator no later than three weeks before your start date.

Morgan Giddings
Student Program Coordinator
Phone: (406) 327-5928
Fax: (406) 329-5688
Email: morgan.giddings@providence.org

Orientation Packet Checklist

Packet Materials:

READ & INITIAL:

____ Student Experience Policy

____ Orientation Material: (which includes)

- ____ Introduction – Providence: Answering the Call to Care, 1856
- ____ Our Mission
- ____ HRO – Caring Reliably
- ____ Doing the Right Thing Right – Providence Code of Conduct
- ____ Cultural Diversity
- ____ Hand Hygiene
- ____ Standard Precautions: Blood borne Pathogens & Other Potentially Infectious Materials
- ____ Environment of Care
- ____ Plain Language - Overhead Announcement
- ____ Workplace Violence Prevention
- ____ Hazcom Training

Complete and sign the following documents and submit to the Student Coordinator:

□ Orientation Packet Checklist
□ Student Profile
□ Orientation Post-Test
□ Acceptable Use Agreement
□ Confidentiality & Non-Disclosure Statement
□ Immunization Verification Form (and supplemental documents)
□ Clinical Inquiry Projects Form (if applicable)
□ Submit badge photo jpeg

I have read the Student Experience Policy and Orientation Material and understand the information provided. I agree to adhere to the conditions of the Confidentiality/Non-disclosure Statement and the Acceptable Use Agreement. By signing, I am verifying that the information on file with the school is accurate and current. I also understand that I, as the student, am responsible for keeping these records current.

Printed name Signature

Providence
St. Patrick Hospital

Student/Instructor Profile

All students participating in a clinical experience will work within their scope of practice as defined by the State of Montana and/or Providence St. Patrick Hospital.

Personal Information:

Name: _____
First Middle Initial Last

Address: _____ City: _____ State: _____

Phone Number: _____ Email Address: _____

Social Security Number: _____ Birthdate: _____

School Information:

School Name: _____ Phone Number: _____

Program: _____

Instructor(s) Name/Contact Information: _____

Start date of clinical experience: _____ End date of clinical experience: _____

Unit/Department Providing Clinical Experience: _____

Signatures:

I understand the Clinical Experience requirements. I understand that I will work within my scope of practice and will not vary from it.

Signature: _____ Date: _____

OFFICE USE

Coordinator: _____ Date: _____

☐ Epic ☐ Pyxis ☐ Badge

Student Program Coordinator
SPH Learning Center
406-327-5928
morgan.giddings@providence.org

Providence
St. Patrick Hospital

Orientation Post-Test

Name: _____ Date: _____

1. If I have a concern about a potential violation of the Integrity & Compliance Program, a Providence policy or standard, or a law or regulation, I should:
   - □ Do nothing
   - □ Tell a coworker
   - □ Pretend I didn't see anything
   - □ Call the Integrity Line, (888) 294-8455 or report it to a manager or instructor

2. As a Providence caregiver, I have a responsibility to follow:
   - □ The Integrity & Compliance Program
   - □ Laws and regulations
   - □ Providence policies and standards
   - □ All of the above

3. The Providence Integrity and Compliance Program applies to:
   - □ Only key leaders
   - □ Only hospital employees
   - □ Only System Office employees
   - □ All Providence caregivers, volunteers and students

4. Any form of retaliation against individuals making harassment complaints, witnesses or other persons involved a harassment investigation is prohibited
   - □ True
   - □ False

5. Downloading of software that is not Providence business related is prohibited. This includes?
   - □ Games
   - □ Movies
   - □ Executable files
   - □ All of the above

6. Only those services that are medically necessary and are supported by valid orders will be submitted for payment to Medicare, Medicaid and other payers?
   - □ True
   - □ False

7. Providence's _____protects me if I raise concerns about potential wrongdoing in good faith.
   - □ EMTLA (Emergency Medical Treatment and Active Labor Act)
   - □ Non-Retaliation Policy
   - □ Mission and Core Values
   - □ Conflict of Interest Policy

8. What is the purpose of the National Patient Safety Goals?
   - □ Improve patient safety
   - □ Provide guidance on how to solve problems
   - □ Provide a framework for healthcare safety
   - □ All of the above

9. Cultural competence and understanding diversity in the workplace is based on?
   - □ Each patient is a unique person
   - □ Individuals are complex
   - □ We celebrate the similarities as well as the differences among people
   - □ All of the above

10. The MOST effective products to use when hands are visibly dirty are?
    - □ Soap and water
    - □ Iodine compounds
    - □ Alcohol-based rubs
    - □ Ammonium compounds

11. Cross-contamination happens when?
    - □ A patient has a drug-resistant infection
    - □ A patient's skin is free of bacterial colonization
    - □ A healthcare worker transfers bacteria from one patient to another
    - □ A healthcare worker decontaminates his or her hands between patient contacts

12. Which of the following best describes a safeguard against exposure to bloodborne pathogens in the healthcare setting:
    - □ Use Droplet Precautions in the care of all patients
    - □ Use Standard Precautions in the care of all patients
    - □ Use Droplet Precautions only in the care of patients known or suspected to have a bloodborne disease
    - □ Use Standard Precautions only in the care of patients known or suspected to have a bloodborne disease

13. Bloodborne diseases are most commonly spread through mother-to-child transmissions, unprotected sex and:
□ Sharing drug needles
□ Contaminated water supplies
□ Eating food prepared by an infected individual
□ Blood splashes or sprays in the healthcare setting

14. Which of the following describes proper use of PPE (Personal Protective Equipment) to safeguard against exposure to bloodborne pathogens:
□ Wear gloves when drawing blood
□ Avoid using a mask during invasive procedures
□ If a surgical mask is worn during invasive procedures, additional eye protection is not necessary
□ If hands are washed immediately after drawing blood, it is not necessary to wear gloves to draw the blood

15. Which of the following is an important bloodborne pathogen:
□ Hantavirus
□ Enterococcus bacterium
□ Human immunodeficiency virus (HIV)
□ Haemophilus influenza bacterium

16. The Environment of Care Emergency Reference Guide located in your area is a great source of information regarding what to do in an emergency of any kind.
□ True
□ False

17. While in the Hospital, volunteers and students are required to wear their badges above the waist at all times.
□ True
□ False

18. An incident report is filed in Datix for all patient, student or visitor incidents, accidents or unsafe conditions.
□ True
□ False

19. Utility failures should be reported to the Facilities Engineering Department
□ True
□ False

20. The "plain language" overhead page "facility alert, fire alarm at the Broadway Building Level 1, Conference Center" indicates a possible fire.
□ True
□ False

21. The "plain language" overhead page in the event of a missing or lost child would be announced overhead as "Security Alert, missing child, female, age 4, brown hair, red pants."
□ True
□ False

22. There are 3 types of overhead notifications, Medical, Security and Facility Alerts.
□ True
□ False

23. Providence St. Patrick Hospital has a no tolerance policy towards Workplace Violence:
□ True
□ False

24. What are the 5 new elements introduced by the New HazCom Standard?
□ Signal Words
□ Hazard Classification
□ Pictograms
□ Hazard Statements
□ Precautionary Statements
□ All of the above

Providence St. Joseph Health

Student/Agency/Vendor/Contractor Health Requirements

In supporting and creating healthier caregiver communities and to promote our vision of Health for a Better World, our student/agency/vendor/contractor partners must have the following health requirements assessed before starting their regular work assignment /rotation/shadow/visitation in any Providence St. Joseph Health facility or affiliate building where patients are treated or caregivers perform work.

Please provide documentation to your administrator to keep on file:

Health Requirement	Check
Annual Health Screen Indicate free of infectious disease, able to work with or without accommodation (specify any accommodations needed) and signed by MD, DO, NP or PA	
Tuberculosis Testing -- Tuberculosis testing; IGRA or Q-Gold blood test or two-step tuberculin skin test current within the last 12 months, and annual as per ministry requirements. If history of positive please provide copies of chest x-ray results after positive TB test and medical clearance note from your provider.	
Measles, Mumps, Rubella (MMR) – Documentation of 2 MMR's at least four weeks apart after the age of one and/or positive laboratory titer or signed declination (Rubella is required in AK)	
Varicella (Chicken pox) – Documentation of 2 doses of varicella at least four weeks apart and/or positive laboratory titer or signed declination	
Hepatitis B (Hep B) - Documentation of Hepatitis B vaccinations (series of 3 Engerix or Recombivax or 2 Heplisav) and/or positive laboratory titer or signed declination where required. (Hep B vaccination is required in Alaska)	
Tetanus, Diphtheria & Pertussis (**Tdap) –** Documentation of vaccination/booster or signed declination	
Annual influenza vaccine -- Documentation of vaccination or signed declination, including reason for declining. Must follow masking requirements of setting.	
COVID vaccination- Documentation of single dose of most current, up-to-date vaccine or written declination for medical or religious purposes. Please refer to local policy for masking requirements.	
Respirator Training: Respiratory Protection (PAPR or N95 Fit Mask Testing), if required by setting or functions performed. If prior training is not for device provided by PH&S, PH&S will provide training/testing as appropriate.	

I understand the declination of some vaccines may limit the locations where I am able to work. I hereby attest that I provided my administrator all the necessary medical documentation as outlined above in order to meet the health requirements of Providence St Joseph Health. I have done this to protect myself, our patients, colleagues and the community.

Signature Printed Name Date

Administrator Signature Printed Name Date

Ideas on where to obtain your childhood and adult immunization immunity records:

- Previous health care employers or any schools you have attended
- Your family Physician or the Health Department where you grew up, which may take a couple weeks.
- Call your state **Immunization Registry Help Desk** as they may have record of your immunizations and can send them to you.

Ideas in where to receive vaccinations:

- Your Primary Care Provider or other walk in clinics
- Local and national pharmacy stores/chains, some located in grocery stores chains.
- Family Practice Residency programs
- Low income or sliding scale clinic’s
- Local Health Department

Providence

Providence SWEDISH | PROVIDENCE Health & Services | CovenantHealth | KADLEC | pacific medical centers

CAREGIVER HEALTH SERVICES

PLEASE RETURN COMPLETED FORM TO CAREGIVER (EMPLOYEE) HEALTH SERVICES

COVID-19 Declination Form 2023-2024

Providence St. Joseph Health and its family of organizations requires caregivers to participate in the COVID-19 vaccination process by either being vaccinated or completing a written declination.

LEGAL NAME:_____ DOB: _____ EMPLOYEE ID#_____

CAMPUS/SITE:_____DEPT:_____PHONE:_____

IF NOT EMPLOYED BY PROVIDENCE, CHECK ONE:

☐ Medical Provider ☐ Volunteer ☐ Agency/Contractor ☐ Student ☐ Other

I AM DECLINING A COVID-19 VACCINE. I ACKNOWLEDGE THAT I AM AWARE OF THE FOLLOWING FACTS:

- *COVID-19 can be very contagious and spreads quickly.*
- *COVID-19 vaccination is recommended for all healthcare workers to protect our patients from COVID-19 disease, its complications, and death.*
- *Although vaccinated people sometimes get infected with the virus that causes COVID-19, staying up to date on COVID-19 vaccines significantly lowers the risk of getting very sick, being hospitalized, or dying from COVID-19.*
- *Persons infected with COVID-19 virus, including those who are pre-symptomatic, can transmit the virus to coworkers and patients, some of whom may be at higher risk for complications from COVID-19.*
- *Some people are more likely than others to get very sick if they get COVID-19. This includes people who are older, are immunocompromised, have certain disabilities, or have underlying health conditions.*
- *COVID-19 may attack more than your lungs and respiratory system.*
- *Some people including those with minor or no symptoms will develop Post-COVID Conditions – also called "Long COVID."*
- *I cannot get COVID-19 from the vaccine and studies show that people who have antibodies from an infection with the virus that causes COVID-19 can improve their level of protection by getting vaccinated.*
- *The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including my patients and other patients in this healthcare setting, my coworkers, my family, and my community.*
- *Side effects after a COVID-19 vaccination tend to be mild, temporary, and like those experienced after routine vaccinations.*
- *I understand I must follow all current infection prevention policies and procedures for my location, such as masking, to limit the possibility of transmission of the virus.*
- *I understand that I can change my mind and agree to provide my vaccination record if I receive the vaccine in the future.*

Resources for future reference:
https://www.cdc.gov/coronavirus/2019-ncov/your-health/about-covid-19.html
https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html
https://www.cdc.gov/ncbddd/humandevelopment/covid-19/people-with-disabilities.html

I am declining the COVID-19 vaccine because of:

☐ My Licensed independent practitioner-documented allergy or medical contraindication to the components of the vaccine

☐ My religious beliefs, including my sincerely held ethical or moral beliefs

Signature: _____ **Date:** _____

Providence
St. Patrick Hospital

Confidentiality and Nondisclosure Statement

I understand that in my involvement with Providence Health & Services and its affiliated organizations (collectively referred to as "Providence"). I will have access to information not generally available or known to the public. I understand that such information is confidential information that belongs to Providence. Confidential data/information includes but is not limited to patient, customer, member, provider, group, physician, student, resident, financial, and proprietary information, whether oral or recorded in any form or medium. Confidential data/information also includes caregiver information that a caregiver does not wish to share. However, nothing in this policy restricts a caregiver's or, if applicable, other individual's, right to disclose wages, hours, and working conditions in accordance with Federal and State Laws.

I understand that information developed by me, alone or with others, may also be considered confidential information belonging to Providence in accordance with Providence policies and procedures.

I will hold confidential, data/information I see or hear in strict confidence and will not disclose or use it except as authorized by Providence, for Providence's benefit.

I will only access confidential data/information that I need to do my job and will only provide such data or information to those who need it.

I understand that unless it is a part of my job function, I cannot remove any confidential data/information from Providence without authorization from my supervisor and that I must return any such confidential data/information at the end of my employment, engagement, or relationship with Providence.

I understand that confidential data/information must be stored securely at all times as defined in Providence policy.

I understand it is my responsibility to become familiar with and abide by applicable laws, regulations, and Providence policies and protocols regarding the confidentiality and security of confidential data/information.

I understand that email is not a secure, confidential method of communication. I will never send Providence confidential data/confidential information to a personal email account or store it on my personally owned computer or mobile device. And when sending messages that include confidential data/confidential patient information to a non-providence.org email address as part of my job functions, I must type "provsecure" in the subject line to encrypt the contents of the email.

I understand that texting and other messaging are not secure methods to transmit confidential data/information and agree not to use these types of communication methods to transmit such information.

I understand that Providence electronic communication technologies (Internet and email) are intended for job-related activities: however, limited personal use is permitted. Personal use is determined as incidental and occasional use of electronic communications technologies for personal activities that should normally be conducted during personal time, such as break periods, or before and after scheduled working hours, and is not in conflict with business requirements of the department. Internet usage is monitored and

audited on a regular basis by Providence management. Providence management also reserves the right to monitor email and telephone usage.

I understand that this Confidentiality and Nondisclosure Statement does not limit my right to use my own general knowledge and experience, whether or not gained while employed by Providence, or my right to use information that becomes generally known to the public through no fault of my own.

I understand that if I breach the terms of this Confidentiality and Nondisclosure Statement, Providence may institute disciplinary action up to and including termination of my employment, engagement or relationship with Providence.

Signature: _____ Date: _____

Printed name: _____ Position: _____

Providence
St. Patrick Hospital

Data Access Acceptable Use Agreement *for* Non-Providence Workforce Members (Attachment A)

Providence Health & Services ("Providence") requires that everyone granted access to our information systems will protect our patients' information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules and other applicable state and federal laws.

I acknowledge that (*please initial*)**:**

_____ Providence is granting me access to systems and information owned or operated by Providence or one of its subsidiaries, and I will have access to confidential information not generally available or known to the public, including protected health information (PHI).

_____ Providence will issue me a unique user ID and password. I agree that I am not permitted to share this user ID or password with anyone. I will never share my password or leave it written down for others to find, nor will I utilize user ID and password auto save functionality on any computer or mobile device.

_____ I agree to immediately notify Providence by calling the Breach Reporting Hotline **866-406-1290**, if I have a reason to believe that any other person may know my user password.

_____ I understand my computer account and password will be considered my computer signature, and I will protect it accordingly. I will keep PHI out of sight and secure it when not in use to prevent unauthorized access.

_____ Federal and state laws protect Providence information to which I will have access, and I will abide by those laws. I understand what qualifies as PHI and that I am required to comply with the HIPAA Privacy and Security Rules.

_____ I agree that I will not access Providence information for which I have no legitimate need. I will not access my own records or records of my family members. I will only access minimum necessary information for which I have a legitimate reason. I understand all activity is tracked based on my user ID.

_____ I agree that I will hold Providence information in strict confidence and will not disclose or use it except (1) as authorized by Providence; (2) as permitted under written agreement between Providence and the Organization named below or myself; (3) consistent with the reasons for my access; (4) solely for the benefit of Providence, its patients, its members, or its other customers; or (5) as required by applicable law.

_____ If I am a member of a Providence medical staff, I understand I may be given access to certain tools as an important part of the delivery of medical services to Providence patients and I will use the tools to benefit Providence patients while engaged in activities that benefit Providence or its patients. I understand that the continuing medical education (CME) I may redeem from these tools is provided to me as a medical staff incidental benefit. I indemnify Providence for any liability if this benefit is not compliant with applicable law.

_____ I understand that e-mail is not a secure, confidential method of communication. I will not include confidential patient information in e-mail communications, unless using an approved secure email method.

_____ I understand that should I need to use Providence network, email, or telephone, it is a privilege that may be revoked if I misuse these services. I also understand that these services may be monitored and audited by Providence.

_____ I understand that should I need to work with Providence data outside of the systems to which I am granted access, I will use secure methods to dispose of files or documents containing PHI or other confidential information.

_____ I understand that if I breach the terms of this agreement, applicable Providence privacy and/or security policies, or applicable law (including without limitation the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH), Providence may terminate my access, and Providence will be entitled to all remedies it may have under written agreement or under applicable laws, as well as to seek and obtain injunctive and other equitable relief, or contact law enforcement.

_____ I will report all suspected privacy and security incidents immediately, but no more than 5 days from the date of discovery, to Providence's toll free **Breach Reporting Hotline number at 866-406-1290**.

I acknowledge that I have read and understand the Providence Non-Employee Acceptable Use Agreement.

Signature: _____ Date: _____

Printed Name: _____ Position: _____

Organization's Name: _____ Work Location: _____

Providence
St. Patrick Hospital

CLINICAL INQUIRY PROJECTS

Will you be conducting a study or project while you are a student at a Providence facility, such as Research, Evidence-Based Practice, or Quality Improvement (as an employee or a non-employee?)

NO - You do not need to fill out the Student Clinical Inquiry Form. However, if at any time in your education, you will conduct a study, you will need to complete the form before proceeding with the study.	**YES** - You will be required to complete the Student Clinical Inquiry Form before beginning your study. Contact the chairs of the Nursing Research & EBP Council for the form: Teresa.Bigand@providence.org Danell.Stengem@providence.org

PHI Includes:

1. Names
2. Phone numbers
3. Fax numbers
4. Electronic mail addresses
5. Social Security numbers
6. Medical record numbers
7. Health plan beneficiary numbers
8. Account numbers
9. Certificate/license numbers
10. Vehicle identifiers and serial numbers, including license plate numbers
11. Device identifiers and serial numbers
12. Web Universal Resource Locators (URLs)
13. Internet Protocol (IP) address numbers
14. Biometric identifiers, including finger and voice prints
15. Full face photographic images and any comparable images
16. All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census: (1) the geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people
17. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older; and

Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the data)

DO:

1. Obtain appropriate permissions to conduct project at your local PSJH facility prior to submitting to the HRPP.
2. If you are a student/resident identify local PSJH sponsor.
3. Align your project in a way that will provide benefit to the hospital(s) in which the project is being conducted.
4. Allow time for HRPP review prior to starting project.
5. Conduct project as submitted to the HRPP. Contact the HRPP Office if revisions are required.
6. Obtain only the data outlined in the summary provided to the HRPP. Projects are subject to audit by compliance.
7. Follow all PSJH and/or local policies.
8. Follow HIPAA law.
9. Present your project finding to appropriate PSJH personnel identified above.

Don't:

1. Make any changes to project without consulting the HRPP Office.
2. Put ANY PHI on personal computers, e-mail or store on thumb-drive.
3. Remove any PHI from PSJH campus.
4. Start your project until a determination has been made by the HRPP.

What if my project requires IRB review/approval?

If your proposed project is determined to be research, you will be informed by the HRPP Office and submission as research will be required.

Badge Photo Guidelines

Use a recent photograph or take a new one which meets **all requirements listed below**:

- **Original, recent color photo**
  - Please do not send a photo of a photo - send an original JPEG.
- **Look straight at the camera**
  - Head not turned or angled in any way.
- **Generous space above the top of your head**
- **Full face visible**
  - No hats/head coverings except for religious reasons. No shaded glasses; blue light blocking tint is fine.
- **Well lit, sharp image**
  - Not blurred, without shadows over you face.
- **Solid**, **neutral background**

Example photo that meets all requirements and was taken using a smartphone camera.

Please rename the file with the student's name and email to morgan.weidow@providence.org with your paperwork.

1. Who do I reach out to if I have questions?

Students and faculty seeking clearance are strongly encouraged to direct questions to their instructor or school coordinator before reaching out to the Student Coordinator, and school instructors/coordinators must submit their introductory email before we are able to receive student documentation. If your instructor or school coordinator directs you to reach out to Providence, please contact the Student Coordinator.

2. How do I know if my information was received? What if I don't receive a confirmation email?

If your documentation was received, you will receive a confirmation email from the Student Coordinator. If you haven't heard back in a week from sending your email, check back in to check on the status of your paperwork.

3. Where can I obtain my immunization records or receive vaccinations?

Ideas on where to obtain your childhood and adult immunization immunity records:

- Previous health care employers or any schools you have attended
- Your family Physician or the Health Department where you grew up, which may take a couple weeks.
- Call your state Immunization Registry Help Desk as they may have record of your immunizations and can send them to you.

Ideas in where to receive vaccinations:

- Your Primary Care Provider or other walk-in clinics
- Local and national pharmacy stores/chains, some located in grocery stores chains.
- Family Practice Residency programs
- Low income or sliding scale clinic's
- Local Health Department

4. Can Providence use a background check I've already completed?

Providence may be able to use a recent background check if it was completed while you were enrolled in your current school program. To meet requirements, the background checks must include:

• SSN trace • OIG sanctions list • GSA/EPLS • Criminal history • Sex offender registry

If you are unsure if your background check includes these requirements, confirm with your instructor or school coordinator and ask them to review it in compliance with the clinical Affiliation Agreement contract we have with your school.

5. How do I know if my school can submit a Tort letter?

Some schools may choose to submit a Tort letter that meets BLS/CPR, background check, drug screening requirements, and health requirements, excluding the COVID-19 vaccination. If you are unsure if your school will be submitting a Tort letter, ask your school coordinator or instructor. If they are unsure if the school will be able to provide this documentation, please have them contact the Student Coordinator. We can send them a Tort letter template that schools are able to use if they find the template helpful.

6. Do I need CPR/BLS certification?

All students and faculty who may have direct contact with patients will need CPR/BLS certification. Direct contact with patients is defined as "clinical or therapeutic interaction with a patient, in a one-on-one or group

setting at the clinical placement setting or an associated location, including but not limited to meetings, examinations, or procedures." If this does not pertain to you, please ask your school instructor or Providence preceptor to email the Student Coordinator to request an exemption.

If you are a current Providence caregiver who is required to maintain CPR/BLS certification as a function of your job, please reach out to the Student Coordinator so that we can provide an exemption.

7. I'm a Providence employee - what do I need to submit?

Current Providence caregivers will not need to complete a background check. Please ensure that your school coordinator/instructor knows that you are a Providence caregiver so that they can include this information on the introduction email they send. Providence caregivers are required to submit all packet forms and have a BLS/CPR certification on file with their school. Please note that while many forms say "non-employee," caregivers must complete these forms since they are not considered caregivers while they are completing their clinical rotations.

8. I've received my clearance email - what's next?

Your Providence preceptor and school coordinator will be copied on your clearance email (for nursing students, emails will just be sent to your school coordinator). Once you have clearance, the Student Coordinator will request Epic access (if applicable), and will give you further instructions on how to obtain your badge. You will be added to the clearance list that security personnel can access.

9. How do I stay connected with Providence to learn about future employment opportunities?

We look forward to getting to know you and your career aspirations through your clinical rotation! Speak with your preceptor and unit manager about your desire to work for Providence now or in the future. Please also complete this brief form, which will help us stay in touch with you about current or upcoming job opportunities at Providence that you may be interested in.