

Southeast Washington Student Intake Packet

St. Mary Medical Center

Kadlec Regional Medical Center



St Mary Medical Center
PSMMCStudents@providence.org



Kadlec Regional Medical Center
AcademicServices@kadlec.org

Dear Student,

Thank you for your interest in Providence Health Care. Please complete the packet in full and return to:

- St. Mary: PSMMCStudents@providence.org
- Kadlec: AcademicServices@kadlec.org

Full Name (First, Last, Middle I)	
School Affiliation	
Rotation Start & End Dates	

COMPLETE STUDENT INTAKE PACKET AND RETURN PROMPTLY

Within this packet you will find the following:

- Acceptable Use Agreement
- Acknowledgement of the Code of Conduct
- Substance-Free Workplace Attestation and Acknowledgement of Substance-Free Workplace Policy
- Non-Employee Confidentiality and Nondisclosure Statement
- EPIC Request Form – This document must be completed and signed by the student*.
***This document will need to be signed ONLY if you require EPIC or network access. Existing students with EPIC access will need to call 844-922-7548 to reactivate your account if it has been more than 90 days since you last logged in on your first day.**
- Providence Corporate Integrity Agreement Compliance Training
 - If not already complete: Register [here](#) for your unique training link to be sent to you. Once the training and post-test are completed, include a copy of your Certification of Completion with this packet.
 - (This is required annually, through 5/2027.)
 - ***If you will only participate in student activities at Kadlec exclusively, this training is not required**
- Student Clinical Passport – This document should be completed in its entirety, signed and dated.
 - An academic representative must sign the Student Clinical Passport
- By signing below, you attest that you reviewed the “General SEWA Healthcare Student Orientation” module in full, available on the SEWA Student Portal.

Signature

Printed Name

Date

PACKET PROCESSING

Please send the completed packet to the appropriate contact listed above for the correct location. A Providence student coordinator will reach out to you once your intake packet has been received. *Thank you* and welcome to Providence. We hope your rotation experience with Providence is rewarding!

Reminder: Onboarding documents must be provided to Providence on an annual basis. Thank you!

THE MISSION

AS EXPRESSIONS OF GOD'S HEALING LOVE, WITNESSED THROUGH THE MINISTRY OF JESUS, WE ARE STEADFAST IN SERVING ALL, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE.



COMPASSION

Jesus taught and healed with compassion for all. –Matthew 4:24

We reach out to those in need and offer comfort as Jesus did. We nurture the spiritual, emotional and physical well-being of one another and those we serve. Through our healing presence, we accompany those who suffer.



DIGNITY

All people have been created in the image of God. –Genesis 1:27

We value, encourage and celebrate the gifts in one another. We respect the inherent dignity and worth of every individual. We recognize each interaction as a sacred encounter.



JUSTICE

Act with justice, love with kindness and walk humbly with your God. –Micah 6:8

We foster a culture that promotes unity and reconciliation. We strive to care wisely for our people, our resources and our earth. We stand in solidarity with the most vulnerable, working to remove the causes of oppression and promoting justice for all.



EXCELLENCE

Whatever you do, work at it with all your heart. –Colossians 3:23

We set the highest standards for ourselves and our ministries. Through transformation and innovation, we strive to improve the health and quality of life in our communities. We commit to compassionate, safe and reliable practices for the care of all.



INTEGRITY

Let us love not merely with words or speech but with actions in truth. –1 John 3:18

We hold ourselves accountable to do the right things for the right reasons. We speak the truth with courage and respect. We pursue authenticity with humility and simplicity.

Kadlec Promise, Mission, Vision & Values

Mission

- To provide safe, compassionate care

Promise

- Know me, care for me, easy my way

Vision

- Health for a better world

Values

- **Safety**-As our highest priority, safety is at the core of every thought and decision
- **Compassion**-We reach out to people in need and give comfort. We nurture the spiritual, physical, and emotional well-being of one another
- **Respect**-We treat everyone with acceptance and honesty, valuing individual and cultural differences
- **Integrity**-We earn the trust of the community through ethical behavior and transparency
- **Stewardship**-We believe that everything entrusted to us is for the common good. We strive to care wisely for our people, our resources, and our community.
- **Excellence**-We hold ourselves accountable to the highest standards of quality and safety
- **Collaboration**-We join together and with others across the community to advance the interest of patients and families

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 ID or 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 activities are 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.

____ 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.

for Non-Providence Workforce Members (Attachment A)

____ 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: _____

Doing the Right Thing Right

Our Code of Conduct

Our mission, vision, values, and promise provide guidance and inspiration as we deliver quality care, make sound, ethical choices, and meet our organizational goals. As workforce members, we are accountable for the integrity of our decisions and actions on the job. The Code of Conduct provides a foundation of expectations for us as we do our work each day.



Ways to report a concern

- Discuss the matter or concern with your immediate supervisor
- Discuss the matter or concern with your department leader
- Discuss with your HR Partner, HR Service Center, or send report via HR Portal
- Contact your local or regional compliance or privacy representative
- Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option.
- For Caregivers in India:
 - From an outside line, dial the direct access number: 000-117
 - At the English prompt dial 888-294-8455

You may report concerns anonymously

We adhere to all laws and regulations and are committed to a workplace culture where all individuals are treated with respect and dignity, regardless of protected characteristics, as defined by local, state, or federal law, including but not limited to race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), genetic information, marital status, age, sex (which includes pregnancy, childbirth, breastfeeding and related medical conditions), gender, gender identity, gender expression, sexual orientation, and military and veteran status.

Quality of Care and Patient Safety

We commit to provide the best, *compassionate* care and service every time and strive to meet and exceed national standards for quality and patient safety.

Stewardship of Resources

We commit to effective stewardship of resources in support of patient care and organizational goals and only use resources for legitimate business purposes.

Conflicts of Interest (COI) Commitment

We will avoid actual or perceived COI and agree to disclose any outside interests or activities, contracts, and relationships that may be in conflict to the organization. We maintain impartial relationships with vendors, research sponsors, and contracts by not requesting or accepting gifts, cash, or cash equivalents.

Ethical and Legal Standards

We conduct ourselves in a professional and ethical manner in support of *justice* and will perform our job duties in accordance with all federal, state, and local laws.

Safeguarding Patient Information and Protecting Privacy and Confidentiality

We take every precaution to safeguard patient information, and we will treat protected health information (PHI) of all with special care and follow all federal, state, and local laws.

Ethical Conduct of Research

We follow the highest ethical standards and comply with all laws, regulations, guidelines, and ethical directives (where applicable) that govern human, animal, and basic applied science research.

Licensure and Certification

We require all health care and education professionals to follow all federal, state, and local laws applicable to licensing, credentialing, and certification requirements. Individuals on the excluded provider lists cannot work for our organization.

Compliance with Applicable Federal and State Laws and Regulations, and Policies

We ensure *excellence* by requiring all parties that work for or on behalf of an employer within our family of organizations learn and follow all laws, regulations, and policies.

Fair Business Practices

We conduct ourselves ethically, honestly, and with *integrity* at all times.

Reporting Violations and Protection from Retaliation

We will use the appropriate method to report any violation or suspected violations of our code(s), fraud, waste, or abuse as required. Retaliation or harassment will not be tolerated.

ACKNOWLEDGMENT OF COMMITMENT TO THE CODE OF CONDUCT

These standards in the Providence Code of Conduct do not, nor were they intended to, cover every situation you may encounter. They provide only broad guidance that is defined in greater detail by the various policies, standards, procedures and guidelines of Providence, your region and your facility.

Confidentiality and Nondisclosure Statement

Name: _____ Position: _____

I understand that in my involvement with the facility I may have access to information not generally available or known to the public. I understand that such information is confidential and belongs to the facility. 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 workforce member information that a workforce member does not wish to share. However, nothing in this statement restricts a workforce member'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 data/information belonging to the organization in accordance with our policies and procedures.

I will hold any confidential data/information I see or hear in strict confidence and will not disclose or use it except as authorized by the facility.

I will only access the confidential data/information that I need to do my job and will only provide such 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 the organization without authorization from my core leader and that I must return any such confidential data/information at the end of my employment, engagement or relationship with the facility. I understand that confidential data/information must be stored securely at all times as defined in our policy.

I understand it is my responsibility to become familiar with and abide by applicable laws, regulations, and our 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 confidential data/information to a personal email account or store it on my personally owned computer or mobile device. When sending messages that include confidential data/information to a non-facility email address as part of my job functions, I must type "#secure#" 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 agree to the acceptable use of computer equipment and resources as outlined in policy.

I understand that 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. At Providence, internet usage is monitored and audited on a regular basis by our organization. The organization 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 the facility or partner organization, 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 or for serious violations of policies related to use or disclosure of confidential data/information including but not limited to viewing of PHI (including demographic information alone) by use of identity look up modules in the electronic health record or by use of other means, for the purpose or personal benefit/curiosity or when there is no business or medical purpose, the facility may institute corrective action up to and including termination of my employment, engagement or relationship with the facility or partner organization.

Signature: _____ Date: _____

Substance-Free Workplace Policy

Providence Shared Services (“ministry”)

Department: Human Resources

Approved by: Chief Human Resources Officer

Date Last Reviewed: 2/5/2025

Date Last Revised: 2/5/2025

Date Adopted: 5/4/2009

Policy Name: Substance-Free Workplace

Scope: This policy applies to all caregivers at the ministry.

Purpose: In keeping with our mission and values, the ministry is committed to providing a workplace free of illegal drug and/or alcohol use and to ensure consistency in the implementation of illegal drug attestation procedures for all applicants who receive conditional offers of employment and all caregivers reasonably suspected of being under the influence.

Terms:

Illegal Drug: Any drug whose use is prohibited or restricted by federal law to include marijuana/THC (psychoactive compounds in cannabis and to include medically prescribed marijuana), cocaine, opiates, amphetamines, phencyclidine (PCP) hallucinogens, methaqualone, barbiturates, narcotics, and any other substance included in Schedules I-V, as defined by Section 812 of Title 21 of the United States Codes and prescription medications that are used in an unauthorized manner.

Impaired: Reduced cognitive or physical abilities which could include but not be limited to: poor judgment, impaired motor senses (sight, hearing, balance, reaction times and reflexes), slurred speech, reduced fine motor skills, erratic behavior, appearing dazed or sedated.

Under the Influence: Caregivers are considered under the influence at work if they have a detectable level of drugs (in excess of trace amounts attributable to secondary exposure) or alcohol in the blood or saliva or have any noticeable or perceptible impairment of mental or physical faculties. The symptoms of influence are not limited to those consistent with misbehavior, or to obvious impairment of physical or mental ability, such as slurred speech or difficulty in maintaining balance.

Medical Review Officer (MRO): A physician with current MRO certification contracted to review and interpret laboratory tests measuring detectable levels of drugs or alcohol. The MRO can review test results, talk with the caregiver, and consider other information in order to make a reportable determination that a drug and/or alcohol test result is positive, negative or inconclusive.

Policy:

1. The ministry strictly prohibits the use, possession, transfer, distribution, manufacturing, sale, purchase or accepting of any illegal drug at any time while on its property and/or while on duty. The ministry also strictly prohibits any attempt to engage in the conduct described above.
2. These restrictions also apply to the use of alcohol unless provided as part of an on-site ministry-sponsored event for non-working staff. Gifts of alcohol are allowed as part of a gift exchange between caregivers provided the alcohol is not opened or consumed on ministry property.

3. Caregivers are prohibited from reporting to work or remaining on duty while under the influence of or impaired by a drug(s) or alcohol.
4. Caregivers taking prescribed or over-the-counter medications will be responsible for consulting the prescribing physician and/or pharmacist to determine whether the medication could impact the ability to safely perform their jobs. Prescription and over-the-counter drugs are allowed when taken in standard dosage and/or according to a physician prescription.
5. Caregivers must report any identified work restrictions to their immediate core leaders prior to commencing work and ensure they are able to safely perform their job functions without risk of harm to themselves or others.
6. Possession, sale, or being under the influence of marijuana is not authorized for purposes of this policy. The legality of marijuana is not a defense to violate this policy. The use of any substance containing detectable amounts of tetrahydrocannabinol (THC) is also prohibited.
7. Violation of this policy may result in corrective action, up to and including termination of employment.
8. Caregivers in positions that are subject to State Department of Transportation (DOT) laws or regulations may be required to meet additional requirements.

Procedures:

1. **Pre-employment/post offer:** New job applicants will be required to complete the post-offer Substance-Free Attestation Form and/or drug screening prior to beginning work at the ministry.
2. **Fitness for duty:** The ministry may require a caregiver to participate in a medical examination to determine fitness for duty. This examination will require the caregiver to provide a saliva, breath and/or blood specimen for drug and/or alcohol testing. Caregivers who refuse to consent to testing will be considered to be under the influence and generally will face termination of employment, even for a first refusal. Consent to testing and search includes a caregiver's obligation to fully cooperate. Upon request, a caregiver must promptly complete any required forms and releases and promptly cooperate in the testing process. The fitness for duty examination may be initiated for any of the following reasons:
 - A. When there is reasonable suspicion that a caregiver is using or under the influence of drugs and/or alcohol
 - B. When a caregiver's conduct is a contributing factor in any accident occurring in the course of work and resulting in a reportable injury or incident
 - C. As part of a caregiver's return to work
 - D. When a caregiver is the subject of a drug diversion investigation and a fitness for duty examination is relevant to that investigation
3. **Investigation and searches:** The ministry expressly reserves the right to search caregiver personal effects, work areas, lockers, desks or file cabinets without prior notice or consent if the ministry reasonably suspects a violation of this policy.
4. **Confidentiality:** The results of any tests and/or information disclosed in the testing process will not be disclosed absent legitimate business reasons or unless otherwise required by law.
5. **Self-referral – Caregiver Assistance:**
 - A. The ministry encourages and expects caregivers who suspects they may have a drug or alcohol problem to seek assistance or treatment before it affects job performance.
 - B. Caregivers with job performance or conduct problems may be subject to corrective action, regardless of whether the problems are caused in whole or in part by the use of alcohol or drugs.
6. **Notice of convictions:**
 - A. Any caregiver who is convicted of violating any federal or state criminal drug statute must notify the ministry within 24 hours of the conviction.
 - B. Any caregiver who is convicted of driving under the influence or driving while impaired must notify the ministry within 24 hours of the conviction if driving is a requirement of their position, assignment, or as required by local/state regulations.
7. **Caregiver responsibility:**
 - A. Unlawful or unauthorized possession or use of drugs or alcohol by any individual within the scope of this policy, or any failure to notify the ministry of convictions as set forth in Section VI, will subject that individual to corrective or disciplinary action up to and including termination of

employment. In addition, for licensed personnel, the ministry may report the violation to the appropriate licensing agency.

- B. It shall be the responsibility of each caregiver who observes or has knowledge of another caregiver whose behavior exhibits an inability to perform job duties or poses a hazard to the safety and welfare of others to promptly report the observation to the immediate core leader. Concerns regarding possible violations by a core leader should be reported to Human Resources. Caregivers reporting concerns about a core leader or other staff will be protected from retaliation for reporting concerns in good faith and should notify their core leader, Human Resources or the Integrity Line if they believe retaliation is occurring.

References: [Substance-Free Workplace Policy Attestation and Acknowledgment Form](#)

Help: For questions about this policy, or assistance with understanding your obligations under this policy, please contact the [HR Service Center](#).

The statements of this policy document are not to be construed as a contract or covenant of employment. They are not promises of specific treatment in specific situations and are subject to change at the sole discretion of the ministry.

Substance-Free Attestation and Acknowledgment of Substance-Free Workplace Policy

Consistent with our mission and values, this healthcare facility is committed to providing a workplace free of illegal drug use and unauthorized prescription drug use.

Pursuant to federal law and rules promulgated by the U.S. Department of Drug and Alcohol Enforcement, the facility must obtain information from students/instructors about past illegal drug use and unauthorized prescription drug use as part of the facility's comprehensive caregiver (employee) drug screening program.

Within the past three (3) years, have you ever knowingly used any narcotics, amphetamines, or barbiturates, other than those prescribed to you by a physician?

- ☐ **Yes**
☐ **No**

Please provide details:

- ☐ By my signature below, I agree to abide by the Substance-Free Workplace policy that prohibits any drug whose use is prohibited or restricted by federal or state law, including but not limited to marijuana/THC (including medically prescribed marijuana), cocaine, opiates, amphetamines, phencyclidine (PCP) hallucinogens, methaqualone, barbiturates, narcotics, and any other substance included in schedules I-V, as defined by Section 812 of Title 21 of the United States Code; and I agree that I will not take any prescription medications in an unauthorized manner.
- ☐ Further, by my signature below, I understand that any violation of the Substance Free Workplace Policy will be grounds for corrective action, up to and including immediate termination of Clinical Education Experience.

Student's Name (Please Print)

Student's Signature

Date

Assigned Ministry (Facility) | Department

Confidentiality and Nondisclosure Statement - Student

Name: _____ Position: _____

I understand that in my involvement with the facility I may have access to information not generally available or known to the public. I understand that such information is confidential and belongs to the facility. 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 workforce member information that a workforce member does not wish to share. However, nothing in this statement restricts a workforce member'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 data/information belonging to the organization in accordance with our policies and procedures.

I will hold any confidential data/information I see or hear in strict confidence and will not disclose or use it except as authorized by the facility.

I will only access the confidential data/information that I need to do my job and will only provide such 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 the organization without authorization from my core leader and that I must return any such confidential data/information at the end of my employment, engagement or relationship with the facility. I understand that confidential data/information must be stored securely at all times as defined in our policy.

I understand it is my responsibility to become familiar with and abide by applicable laws, regulations, and our 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 confidential data/information to a personal email account or store it on my personally owned computer or mobile device. When sending messages that include confidential data/information to a non-facility email address as part of my job functions, I must type "#secure#" 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 agree to the acceptable use of computer equipment and resources as outlined in policy.

I understand that 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 our organization. The organization 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 the facility or partner organization, 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 or for serious violations of policies related to use or disclosure of confidential data/information including but not limited to viewing of PHI (including demographic information alone) by use of identity look up modules in the electronic health record or by use of other means, for the purpose or personal benefit/curiosity or when there is no business or medical purpose, the facility may institute corrective action up to and including termination of my employment, engagement or relationship with the facility or partner organization.

Signature: _____ Date: _____

Data Access Request Form
for Non-Providence Workforce Members

Fill in the information below to request Providence Network Access and EPIC.

PLEASE PRINT CLEARLY WHEN ANSWERING THE QUESTIONS BELOW:

First Name:	MI:	Last Name:
Job Title (Student Type):	Email Address:	
Street Address:		
City:	State:	Zip Code:
Phone Number:		
Have you had access to the Providence Computer Network in the past? (<i>circle your answer</i>) Yes / No		
If you had previous access, provide your login ID:		

In order to maintain user integrity and reduce duplication, the following identifiers are required for PSJH access:

<u>Last 4-digits</u> of your Social Security Number:	Date of Birth:
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My Signature below indicates that the above information is true and correct.

Signature:	Date Signed:
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Student/Faculty Clinical Passport

STUDENT _____
SCHOOL _____
PROGRAM _____

PHONE _____
EMAIL _____
ROTATION DATE _____

Disclaimer: By contract with your academic institution, all students and faculty participating in learning experiences at Providence St. Joseph Health must meet the following health and safety requirements. The academic institution is responsible for ensuring that requirements have been met prior to participation in the clinical experiences. Records will be kept at the academic institution and random reviews by Providence St. Joseph Health will occur on a regular basis. Documentation must always meet requirements at all times.

Tuberculin Status (Initial - Completed no more than 12 months prior to start of rotation)	Check
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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.

MMR (Measles, Mumps, Rubella)	Check
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Documentation of 2 MMR's at least four weeks apart after the age of one and/or positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed:

1. Written vaccination declination
2. Acceptance of vaccine

(Rubella vaccination is required in Alaska)

Varicella (Chicken pox)	Check
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Documentation of 2 doses of varicella at least four weeks apart and/or positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed:

1. Written vaccination declination
2. Acceptance of vaccine

Hepatitis B (Hep B)	Check
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Documentation of Hepatitis B vaccinations (series of 3 Engerix or Recombivax or 2 Heplisav) and positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed:

1. Written vaccination declination
2. Acceptance of vaccine

(Hep B vaccination is required in Alaska)

Tetanus/Diphtheria/Pertussis	Check
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Documentation of vaccination/booster or signed declination

Influenza (Annual)	Check
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Documentation of vaccination or signed declination, including reason for declining.

BACKGROUND CHECKS – Must be current, completed no more than 1 year prior to start of rotation.	Check _____
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- National Criminal Background Check and Washington State Patrol Background Check (WATCH) upon admission/re-admission and re-entry/hire to program to include all counties of residence & all Washington State counties per RCW43.43.830 and OIG and GSA screens. Excluded Provider search on:
 - 1. OIG <http://exclusions.oig.hhs.gov/>
 - 2. GSA <http://www.sam.gov>
- Washington State Patrol Background Check (WATCH annually thereafter), <https://watch.wsp.wa.gov/>
- Criminal History Disclosure (annual) and kept on file by education institution

COVID-19 Vaccination – All students are required to adhere to the same procedures as Caregivers and must also follow:	Check _____
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Documentation of updated (most current) COVID-19 vaccine or a written declination for medical or religious purposes.

AHA/BLS Course (Course must be American Heart Association (AHA) BLS Provider	Date of Card Expiration _____
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Card must be current and not expired. Renewal due every two years

Respirator Training	Check _____
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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.

INSURANCE – Professional Liability Policy	Date of Policy Expiration _____
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Policy held by academic partner, as outlined in Clinical Education Agreement.

* Students who are granted exemptions or sign declinations may be subject to additional safety protocols including wearing a mask or other personal protective equipment, social distancing, and/or safety protocols at our discretion.
 ** Providence reserves the right to override any exemption request or declination and deny the student's clinical rotation experience for any or no reason at our discretion to maintain patient, faculty, and student safety.

ATTESTATION OF ACCURACY OF RECORDS

To be completed by an appointed representative of the Academic Partner

By my signature, I _____ (print name) certify that I have been informed of the immunization and vaccination requirements for students as outlined above.

I further certify that I have verified the accuracy and completeness of the student's immunization and vaccination records according to the above requirements, and that the information contained therein is accurate and complete to the best of my knowledge. I understand that I am responsible for maintaining, and procuring upon request, documentation of above information.

School Representative Signature

Date

School Representative Printed Name

Phone Number

School Representative Email