Rev. 1/15/2024

STUDENT/INSTRUCTOR CHECKLIST

Memorial Medical Center

Name:_____
Educational Institution:_____
Program: _____
Start and End Clinical Dates: _____

Completed forms are needed in Human Resources at least 2 weeks prior to start of clinical rotation.

- ❑ Affiliation Agreement for this student's program is current.
- ❑ Letter from the Educational Institution indicating scope and length of time at MMC.
- ❑ Sign Confidentiality/Conflict of Interest Agreement (*attached)*
- ❑ IT Security Access Forms (*attached)*
- ❑ New Mexico Caregivers Criminal History Screening Program
  https://www.nmhealth.org/about/dhi/cchsp/bgck/
  (Third party/vendor background checks typically do not meet the requirements of the New Mexico Caregivers Criminal History Screening Program)
- ❑ Clearance through Employee Health Office. ***COPY OF RECORDS TO INCLUDE:***
  - TB Test within past 12 months (Positive Reactors – symptom checklist).
  - 2 MMR vaccines or Rubella, Rubeola (Measles) and Mumps titers
  - TDAP vaccine times one, then Tetanus vaccine every 10 years
  - Hepatitis B series or titers for all clinical areas (or declination waiver)
  - Varicella (Chicken Pox) titers or proof of 2 vaccines
  - Flu Shot (Required if in season, October- March)
  - We follow the most current guidance from CDC regarding COVID vaccination. Please refer to https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html
  - Passed approved drug screen (at least 10 panel) within past 12 months.
- ❑ Proof of completion of Online Orientation in HealthStream (Transcript):
  - ***Memorial Medical Online Orientation- Use most current version on website below***
  - ***https://mmclc.org/students-and-contract-affiliates***
- ❑ Acknowledgement of proper **Parking Area Designations** and **"No Pass Zone"** expectations in patient care areas (*attached for your reference)* _____*(initial)*
- ❑ Acknowledgement that as safety precautions and guidance may change, Educational Institution and Student agree to abide by said changes. _____*(initial)*

I, (print name)_____, have been informed of and given the information regarding the subjects listed above. I understand the documents presented to me and agree to abide by all policies and procedures referenced above.

_____(Initial) I understand I must return my badge to my instructor or MMC Human Resources Department at the end of the semester or completion of my clinicals, whichever comes first.

_____ _____
Printed Name/ Signature Date

Phone Number:_____ Email: _____
Address: _____
_____

Date Badge Issued:_____Badge number:_____Returned: _____

LEGAL Name Please

LifePoint IT&S Security Access Form (Facility)

Student Access

(1) Applicant Last Name	(2) Applicant First Name	(3) MI or "NA"

(4) Home Address	(5) City, State, Zip code

(6) Phone Number	(7) Date of birth	(8) Last Four of SS #
☐☐☐-☐☐☐-☐☐☐☐		XXX – XX – ☐☐☐☐

(9) User Type ☐Life Point

☐ Student Program _____ Semester (level) _____

☐ Start and End Dates _____

Expiration and Approval Requirements — Expiration date must be supplied in field 10 for "Contractors" and "Vendors". The expiration date should be the end of the contract or engagement period.

(11) Department #	(12) Department Name (School)	(13) Job Title Employed at MMC [ ] Yes

(14) Universal ID	(14a.) Network login if different from UID	(14b) Domain

(15) Applicant Signature	(16) E-Mail Address	(17) Date

Authorizing Security Coordinator Statement — By signing this request I am stating that I have reviewed the above information for completeness and it is accurate to the best of my knowledge. Also I have reviewed the Information Security Agreement and verified that it has been completely filled out and signed. Also that I verify this request and authorize its processing. **2 signatures required.**

(18) Instructor Signature	(19) Security Coordinator Signature	(20) Date
	(21) Security Coordinators Printed Name	(22) Phone Number of HDIS / LSC ☐☐☐-☐☐☐-☐☐☐☐

*** Please provide Instructor contact information below for proper processing otherwise access will be delayed.**

(23) Instructor Printed Name	(24) Instructor E-Mail Address	(25) Instructor Contact Number
		☐☐☐-☐☐☐-☐☐☐☐

Action: ☐ New ☐ Change ☐ Delete ☐ Terminate Effective Date:_____

Access Granted By HDIS/LSC		Other Comments
☐ CPCS (MEDITECH)		
☐ Internet Access		
☐ Additional Access:_____		

Confidentiality and Security Agreement

I understand that the facility or business entity named below (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with individually identifiable health information and protected health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will not use company systems to access patient information if it is not necessary to perform my job related duties. This includes NOT accessing my own health information or that of my child or person's for which I am personal representative via the company systems. The Company's Privacy and Security Policies are available through the Company , copies of which will be provided upon request. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation, even if the patient's name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or deletions of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Company's Privacy and Security Policies at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of Company employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up electronic media devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
    a. Use only my officially assigned User-ID and password (and/or token (e.g., Multi-Factor Authentication "MFA").
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
15. I will never:
    d. Share/disclose user-IDs, passwords or MFA.
    e. Use tools or techniques to break/exploit security measures.
    f. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Facility Information Security Officer, or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.
18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information and will ensure that any such employee will execute their own Confidentiality and Security Agreement.
19. I understand that the Company may, at its sole reasonable discretion, rescind any person's access to any information system at any time. I further understand that if I am a member of the medical staff, any violation of the terms contemplated herein or of the facility's rules and regulations, may subject me to disciplinary action pursuant to the facility's medical staff bylaws .

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Vendor/Office Staff/Physician Signature	Facility Name and COID	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name	

Memorial Medical Center

Confidentiality/Conflict of Interest Agreement

Confidentiality:
As a student of_____, I acknowledge the importance of confidentiality with respect to the affairs of Memorial Medical Center. In light of this acknowledgement, I agree to keep confidential all information acquired in this role, pertaining to this organization and any related activities.

It is very important that I agree to and understand the need to protect the privacy of all guest/patients and team members of Memorial Medical Center.

By my signature below, I agree to:

- Conduct myself in the best interests of MMC in conjunction with _____.
  (School/Institution)

- Not disclose any material, financial, or other beneficial interest in any healthcare organization or any entity providing goods/services to the hospital, or which competes with the goods/service provided by MMC

- Not disclose any transaction with the hospital resulting in any material, financial, or beneficial interest.

- Refrain from using any information obtained within the scope of my responsibilities at MMC, to my material, financial, or other beneficial interest or the interest of any other company, agency, organization, person, or association with which I am affiliated or related.

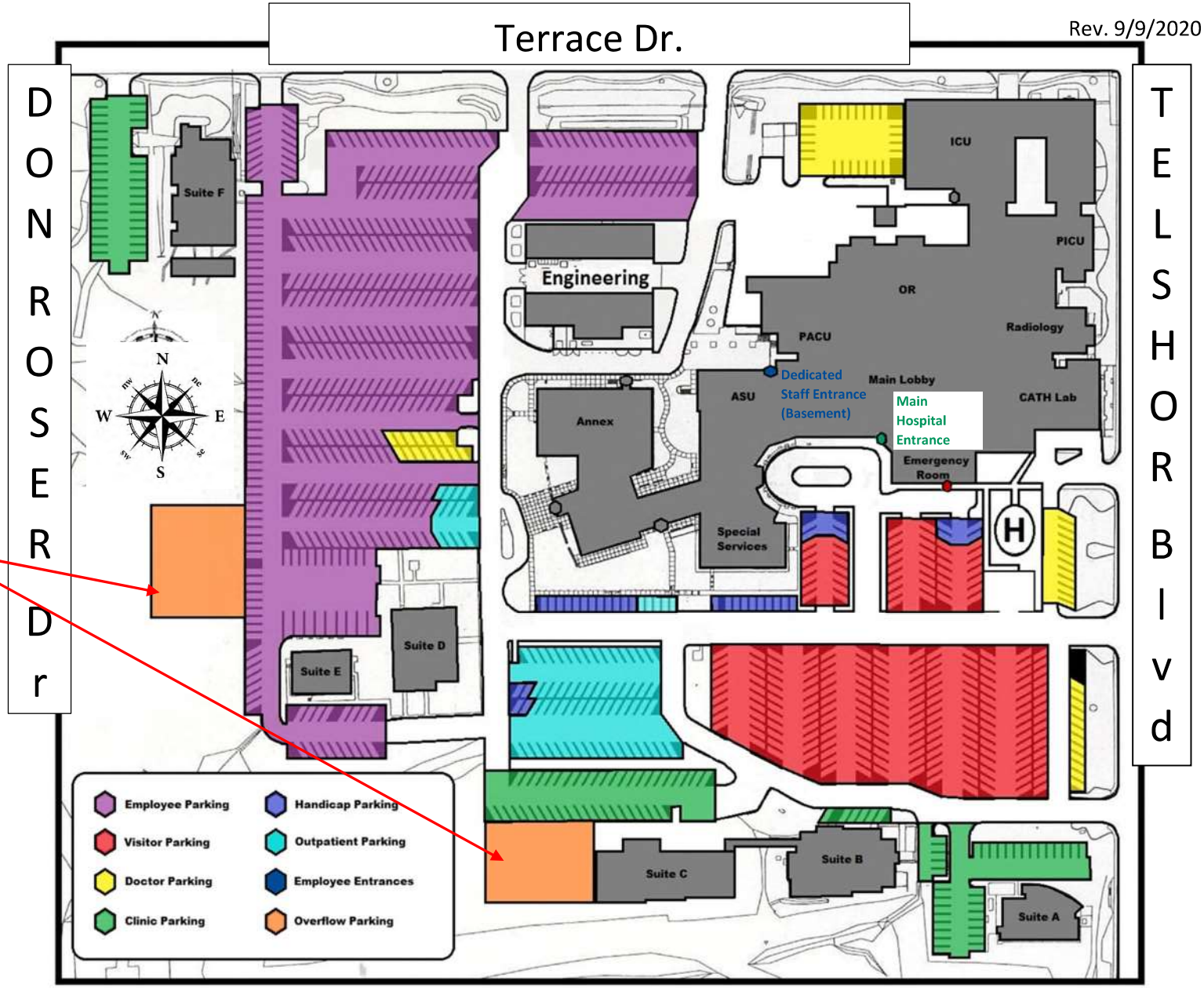
I also understand that any violation of this agreement may result in official sanctions that could include the termination of my relationship with Memorial Medical Center.

_____ _____
Signature Date

Memorial Medical Center

Parking Area Designations

Rev. 9/9/2020



Student/ Instructor Parking in **Orange** Designated Area(s)

- At Memorial Medical, it is important that all of our patients, visitors, and healthcare providers have accessible and efficient parking opportunities.
- In the map above, multiple color-coded areas are defined for their intended audiences, based upon volume, frequency, and need.
- Please review and understand which area(s) of campus are appropriate for you to park your vehicle.
- Be alert to updates on parking policies forthcoming.
- Parking violations are subject to vehicle towing at owner's expense.

Rev. 6/7/2021

Memorial Medical Center is a **NO PASS ZONE*.**

What does this mean? Anytime a patient call light comes on, any employee or student has the responsibility of answering it. The focus is addressing the need(s) of the patient, not just answering the call light.

FOR STUDENTS: During our COVID-19 Pandemic we are not permitting students to enter a room or care for a patient with a suspected or confirmed COVID-19 infection. Please still participate in alerting a member of the MMC team should a call light come on for this patient population.

How is it done?

- A call light comes in the department where you are, you enter the patient's room, perform hand hygiene. Introduce yourself to the patient. Let them know who you are, where you are from and why you are in their room. Example; "Hello my name is Mandy from _____, I saw that your call light was on, how may I help you."
- If the patient's need is within your ability to perform, take care of the need right then and there. Ask if there is anything else you can do for them before you leave. If there isn't anything else, thank them and exit. As you exit the room, perform hand hygiene and exit the room with a feeling of accomplishment knowing you helped one of our patients.

What can you do?

- Moving items such as the bedside table, phone, box of Kleenex, or other personal items within reach of the patient.
- Assist the patient with making phone calls, or using the call light controller to change the channels on the TV.
- Turn on or off lights in the room.
- Obtain a pillow, blankets, wash cloths, gowns or other toiletries from the supply room on the unit.
- Open or close privacy curtain.
- Obtain any other non-medical miscellaneous items such as pens, paper or magazines.

What you should not do if this is patient is not assigned to you (and/or you lack the ability):

- Physically assist a patient out of bed or chair
- Turn off any alarms.
- Enter Isolation rooms (unless trained).
- Offer pain relief.
- Explain clinical matters, tests or treatments.
- Deal with IV issues.
- Move meal trays or water pitchers or assist with eating or drinking.
- Raise or lower the bed, reposition the patient.
- Remember to always use the phrase "I'm sorry but I am not trained to do that, I will get someone to assist you as soon as possible."
- WHEN IN DOUBT CALL THE NURSE!

Resources available to you:

- Your instructor
- Patient's nurse or tech
- Team Leader
- Clinical Manager
- Director

Thank You!!!