FLOYD

Student Rotation/Preceptorship Application Packet

Floyd Medical Center is proud of its status as a teaching hospital and we place a great deal of value on the student experience. The students who rotate through our facility today are the providers and administrators that will continue Floyd’s legacy of excellence in the future. Our commitment to excellence has led us to partner with Blue Ridge Area Health Education Center (AHEC) for the processing of all required student documentation. This documentation helps us to ensure that our patients are protected and our students are adequately prepared.

Any student interested in pursuing a clinical rotation or preceptorship Floyd should follow the process below two weeks before their start date.

Requirements Checklist

☐ Complete the Student Passport Form.

☐ Complete the AHEC Network Student Profile and Support Form.

☐ Review and sign Code of Conduct.

☐ Review and sign Student Review of Medical Records.

☐ Provide a copy of a current Background Check unless on file with your college/university.

☐ Complete online orientation at www.floyd.org/articulate using the following to access the section. Print your results and submit with the additional forms in this packet.
  - Username – student09
  - Password – Floyd09

☐ Send completed Clinical Rotation/Preceptorship Application Packet by email to students@floyd.org or fax 706.378.3113.

A representative from Blue Ridge AHEC will review the documentation and will follow-up with you regarding your status. Once all documentation has been approved, Blue Ridge AHEC will provide instructions to the student on how to receive a name badge and verify their start date.

If you have additional questions about completing your requirements, contact Misty Drake, Blue Ridge AHEC Health Professional Liaison at 706.235.0776 ext. 209
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<th>First Name:</th>
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<td>Instructor</td>
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Would you consider working in a rural or medically underserved area?  
Yes_______  No_______

Rotation Information:  
Begin date:  
End Date:  
# Days at Site:  
# Clinical Training Hours:  

Course Coordinator Information:  
Last Name, First Name:  
Title:  
Specialty:  
CNM CRNA DO Anes ER Fam  
MD NP OT PA Int Neuro OBG  
PharmD PT RN Peds Pharm Psy  
RT SP Surg  
Other Other |

Preceptor Site Name (company):  
Address (street address, city, state, zip):  
Phone:  
Fax:  
Email:  

Support Provided:  
Travel  
Housing  
Placement  
OVID  
Other  
Guide  
Housing:  
Community $  
AHEC $  
Traveled From:  
Traveled To:  
Total Round Trip Miles:  
Date Received:  
Approved:  
Comments:  
Date Paid:  
Check Number:  
Total Amount:  

Revised: 4/30/2009
FLOYD MEDICAL CENTER
CODE OF CONDUCT

As a provider of quality health care services, Floyd Medical Center must at all times maintain the highest possible standards of service and efficiency in meeting the needs of our patients and customers. Patient comfort, confidentiality, and care must always be of the utmost concern. All employees, including contract and temporary, are integral members of the FMC team. As members of professional team, employees are expected to take their work seriously and conduct themselves in a dignified manner that is respectful to patients, their families, visitors, physicians, and certainly our co-workers.

Persons whose behavior is determined inappropriate may be asked to leave the premises.

PERSONAL APPEARANCE AND DRESS

Discretion in style of dress is essential to the efficient operation of Floyd Medical Center. Employees and other representatives of the organization are, therefore, required to dress in business attire that is appropriate for the operating unit. Excessive jewelry or perfume as well as clothing that is extreme or in poor taste should be avoided. Please use good judgement in your choice of work clothes and accessories that best represents you and the organization.

Women will be expected to wear dresses or blouses and skirts/slacks. Men will be expected to wear shirts and slacks and ties when appropriate. Questions regarding appropriateness of an article of clothing should be directed to a member of management.

Security and Confidentiality Agreement for Volunteers, Students and Temporary/Contracted Staff

As a member of the Floyd Medical Center workforce, and as a condition of my assignment at Floyd Medical Center I agree to the following:

1. I will treat all patient information received in the course of my assignment with FMC as confidential and privileged information.
2. I will not access patient information unless I have a need to know this information in order to perform my duties.
3. I will not disclose information regarding FMC's patients to any person or entity, other than as necessary to perform my duties.
4. I will not log on to any FMC computer systems using a password other than my own.
5. I will safeguard any computer passwords provided to me and will not post them in a public place such as the computer monitor or anywhere else they may be easily found.
6. I will not allow anyone, including other employees, to use my password(s) to log on to the computer.
7. I will log off the computer as soon as I have finished using it.
8. Unless it is required by my duties or requested by my supervisor, I will not take patient information from FMC's premises in paper or electronic form without first receiving permission from my supervisor.
9. Upon cessation of my assignment with FMC, I agree to continue to maintain the confidentiality of any information I learned while here.
10. Upon cessation of my assignment with FMC, I agree to turn over any keys, access cards, or any other device that would provide access to the FMC premises or its information.

I understand that violation of this agreement could result in disciplinary actions up to and including dismissal.

____________________________________________________________________
Date Signature
FLOYD MEDICAL CENTER
STUDENT REVIEW OF MEDICAL RECORDS
MEMORANDUM OF UNDERSTANDING AND AGREEMENT

Floyd Medical Center understands that the review of certain medical records is a necessary and vital part of the educational process for students of nursing and other medical professions. Students are permitted to review medical records only if the student understands the following rules regarding confidential patient information:

1. All content within the medical record is confidential and privileged information. Students may request review of a record only when they have been involved in the patient’s care or with the approval of their clinical instructor.

2. Students may make personal notes based on the chart content, but NO INFORMATION IN A PATIENT’S CHART MAY BE COPIED WITHOUT EXPRESS WRITTEN PERMISSION FROM THE DIRECTOR OF HEALTH INFORMATION MANAGEMENT OF FLOYD MEDICAL CENTER OR HIS/HER DULY APPOINTED DESIGNEE.* If you believe that copied information is essential to your review and case preparation, contact the Health Information Management Department at (706) 802-2150.

3. The HIPAA Privacy Rule (45 C.F.R. 164.500) designates the following details as individually identifiable information. These details should be omitted from verbal or written reports unless the detail is medically necessary for the study or report:
   • Patient names, or names of the patient’s family members, friends, or others involved in the patient’s care
   • Addresses, except county and state
   • Any dates, including birth date, dates of admission and discharge, and date of death
   • If the patient is older than 89, specific age may not be given; a general statement such as “the patient’s age is 90 or older” is acceptable
   • Telephone numbers, fax numbers, and/or E-mail Addresses
   • Social Security numbers
   • Medical Record numbers and/or Account numbers
   • Health insurance plan membership and/or beneficiary numbers
   • Certificate/license numbers
   • Vehicle identifiers and serial numbers, including license plate numbers
   • Device identifiers and serial numbers, for example, cardiac pacemaker serial numbers
   • Website addresses (URL’s) and/or Internet Protocol (IP) address numbers
   • Biometric identifiers, including finger and voice prints
   • Full face photographic images and any comparable images
   • Any other piece of information that may allow someone to identify the patient

I HAVE READ AND UNDERSTOOD THIS AGREEMENT. I FURTHER UNDERSTAND THAT MY USE OR DISCLOSURE OF INFORMATION FROM THE MEDICAL RECORD BEYOND WHAT THIS DOCUMENT ALLOWS WILL BE REPORTED TO MY CLINICAL INSTRUCTOR AND MAY RESULT IN TERMINATION OF MY SCHOOL’S APPLIED LEARNING EXPERIENCE CONTRACT WITH FLOYD MEDICAL CENTER.

________________________________________  ______________________________________
Student Signature                             Student Name (Printed)

________________________________________
Student Address & Phone:                      Date: ________________________________

*Students of medical imaging (radiology technicians, etc.) will be permitted to sign out films from the Radiology Department without obtaining permission form the Director of HIM. Release of these films is necessary for formal classroom reviews/critiques as required by clinical affiliation agreements.