Student Placement Form

Date:_____

_____

Last name First Name MI

Address: _____

_____

Phone: _____ Gender: ☐Male ☐Female

Email: _____ Date of Birth:_____

Do you have a license number: ☐Yes ☐No If yes, attached copy of license: ☐Yes ☐No

Have you been placed as a student at San Francisco General Hospital before: ☐Yes ☐No

If yes, date(s):_____ Department:_____

Education

Please only include the applicable degree for the student placement experience.

School Name:_____ School City/State:_____

Area of Study/Practice:_____

Type of Degree:_____

Approved School: ☐Yes ☐No Approved Program: ☐Yes ☐No *If **no** for either, please contact your preceptor or the Department of Education & Training @415.206.4655. **Do not** proceed until further notice.*

Start Date:_____ End Date: _____ Evaluation for Student Required: ☐Yes ☐ No

Hours/Time Required: ☐Yes ☐ No If yes, what is the requirement (hrs/wks): _____

Course Title:_____ # of Credits/Units:_____

School Contact Name: _____ *Title:*_____

School Contact Email: _____ *Phone:*_____

*School Contact License Number (if applicable):*_____

Course objectives attached: ☐Yes ☐ No ☐ N/A Student contract attached: ☐Yes ☐ No ☐ N/A

Student Placement

Department	Responsibilities	Schedule/Shift

Signature of a San Francisco General Hospital (SFGH) employee or preceptor named below indicates the student arrangements have been agreed upon by both parties.

Preceptor Name :_____ Signature:_____

Preceptor Email:_____ Preceptor Phone:_____

Health Requirements

*Students are **required** to provide proof of immunizations, screenings and/or titers of below BEFORE starting placement. Although not required, we strongly recommend Hepatitis B screening and vaccination. For clinical students, health screening is required at the beginning of every clinical rotation. Complete below and show proof to the preceptor/SFGH staff. Actual records are not needed; do not attach.*

Health Screening Records	Date(s)	
Rubeola (Measles): Vaccinated or Titers showing immunity		
Rubella (German Measles): Vaccinated or Titers showing immunity		
Varicella: Vaccinated or Titers showing immunity		
Mumps: Vaccinated or Titers showing immunity		
Tuberculosis: PPD negative or chest x-ray negative (within one year and 3 months of projected start date, two tests total)	**1 year**	**3 months**
Proof of Hepatitis B		
Seasonal Flu (flu season only)*		

**Contact the Department of Education & Training to see if it is an active flu season. Typically the flu season is from Fall through Winter.*

Emergency Contact

Please provide a contact person in case of an emergency while on the San Francisco General Hospital campus or affiliated clinics.

Name: _____

Relationship: _____

Phone #1: _____ Phone #2: _____

Health Data Access

In addition to completing below, the preceptor must complete the Invision/LCR Request form and the student must complete the Online User Confidentiality and Security Agreement (forms available on the DPH intranet).

Health data access needed: ☐Yes ☐ No If no, please proceed to the next section.

Reason for request: _____

_____

- I understand and agree that it is my legal and ethical responsibility to maintain the confidentiality of all patient medical records and the patient information they contain.
  Initial: ____

- I understand that that SFGH conducts routine random audits of who gains access to medical records and that the State of California assesses heavy fines for institutions and individual health workers viewing any patient medical record without a direct need to know.
  Initial: ____

- I understand and agree that the records must not be removed from the Health Information Systems Department for any reason.
  Initial: ____

- I have received and reviewed the Health Insurance Portability and Accountability Act (HIPPA).
  Intial: ____

Oath of Confidentiality

As a condition of clinical placement, conducting research, a student internship or the observation of patient care at San Francisco General Hospital and Trauma Center, I _____, agree not to divulge any information obtained in the course of such training or research to unauthorized persons, and not to public or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable. I further agree not to divulge or public general patient information or statistics without prior authorization from my preceptor or hospital administration. I further agree to hold in strict confidentiality all matters discussed in Medical Staff of hospital committee meetings to which I might be privy. I recognize that the unauthorized release of confidential information may make me subject to civil action under provisions of the Welfare and Institutions Code.

Signature:_____ Date:_____

Orientation

I attest that the above named student has been orientated to the hospital by attending New Employee Orientation held on _____, has received appropriate written material and introduced to department/unit/clinic protocol and standards.

Preceptor Signature: _____ Date:_____

Preceptor Name:_____ Dept./Unit:_____

Student Declaration

I certify that the information provided on this form is true, accurate and complete. I agree to provide the immunization/screening records upon the hospital's request. I understand that any false information will cause my disqualification in any programs on the San Francisco General Hospital (SFGH) campus and affiliated clinics. If placed, I recognize that all confidential information obtained or observed at SFGH is in confidential nature. I agree, that at all times, to ensure the confidentially of all sensitive information I have contact with, comply with applicable laws and maintain patient privacy. I understand that failure to comply with any of the above requirements may result in cancellation of the placement.

Signature:_____ Date:_____

Submission

Submit forms addressed to Student Placements (scanned forms are acceptable as original documents) to your assigned preceptor, SFGH staff contact or department. If you have any questions regarding this form, contact your preceptor (preferred) or the Department of Education and Training at 415.206.4450.

Department Use Only—Received Date:_____ Initials:_____