PENNSTATE HERSHEY Nursing

Request for Nursing Clinical Experience
Penn State Milton S. Hershey Medical Center
Nursing Education and Professional Development

Name Date of Request

Email Phone ( )

School

School Contact Information: *Name/Title* _____

Address _____

City/State/Zip _____

Email _____

Type of Request: Check one Undergraduate ____ Graduate ____ Post Graduate _____

Describe the criteria of your request_____

_____

Requested Dates _____ Number of Clinical Hours Requested _____

Please attach a copy of the course objectives for this clinical request.

Clinical requests are granted for 1 academic semester or term. A continuation of a request requires another request form be submitted and approved. Requests must be submitted at least 1 month prior to the requested start date.

Please complete this portion after confirmation of a clinical agreement & submit to nursing@hmc.psu.edu

Confirmation of Student/Preceptor Clinical Agreement

Name of Preceptor Email

Clinical Site Work Phone

Office Use Only

Request sent:_____

Approved:_____

Evaluation received:_____

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

PENNSTATE HERSHEY
College of Medicine

Confidentiality Agreement

Penn State Hershey Medical Center and the College of Medicine (PSHMC/COM) are critically dependent upon information and information systems to fulfill the organization's missions. Patients, students, business associates and workforce members expect that reasonable and prudent measures will be taken to safeguard information entrusted to PSHMC/COM.

Federal and Pennsylvania state laws and standards regulate the use and disposal of Protected Health Information (PHI) and certain other information. I am permitted access to PSHMC/COM information only to the extent required to perform my specific duties and responsibilities and authorized activities. Reading, discussing, copying, and/or otherwise using or disclosing PSHMC/COM information for other than legitimate PSHMC/COM purposes is prohibited. Failure to comply with any of the information in this document may result in disciplinary action and/or legal action. To help individuals understand their role in safeguarding valued information PSHMC/COM utilizes the following broad classifications of information:

PHI is defined by the United States Department of Health and Human Services under the Standards for Privacy of Individually Identifiable Health Information legislation known as the Health Insurance Portability and Accountability Act (HIPAA). Information that is created or received by PSHMC/COM and concerns an individual's past, present, or future medical condition is PHI. PHI must only be accessed by authorized personnel; this classification includes PHI stored or transmitted in electronic formats.

Confidential Business Information (CBI) is sensitive information necessary to perform certain job functions or PSHMC/COM operations; this information must only be accessed and used by authorized personnel. Examples include: compensation data, contracts, employee evaluations, individual's social security numbers, passwords, strategic agreements.

Other Non-Public/Internal Information (non-public information): Certain internal information is intended for use and distribution only within PSHMC/COM and in some cases, with Business Associates (e.g. legal advisors, consultants, vendors, etc.). Unauthorized disclosure of this information to external parties may create problems for the PSHMC/COM, customers or Business Associates. Examples of this type of information include: information available through the PSHMC/COM Infonet such as internal directories, policies and disaster plans.

For direction pertaining to PHI, contact the Privacy Officer. For direction pertaining to other confidential information and/or the security of electronic information or resources, contact the Information Security Officer.

I certify that I have completed the PSHMC/COM HIPAA Privacy and Information Security training, an equivalent session approved by the Privacy Officer or Information Security Officer, or participated in an active conversation with my Hospital/College employee sponsor; and understand my role in safeguarding and disposal of sensitive information.

_____ _____ _____

Name (please print clearly) Phone (non-workforce member) E-mail (non-workforce member)

_____ Date_____

Signature

_____

Parent/Guardian co-signature (required for individuals under the age of 18)

Affiliation – Please Check One Box			
PSHMC Employee ☐	PSU-COM Employee ☐	PSU Employee ☐	Volunteer ☐

Non-Workforce Members

Name of Hospital/College employee sponsor _____ _____ _____ _____

Department Phone E-mail

Affiliated Student ☐ Name of Affiliated School_____

School Contact (e.g. Faculty, Program Coordinator Advisor, etc)_____

Authorized Observer (e.g. visitor) ☐ : Affiliated Organization: (name of Covered Entity, vendor, etc.)_____

Date: April 2008

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_____ _____ _____

Name (please print clearly) Phone (non-workforce member) E-mail (non-workforce member)

_____ Date_____

Signature

_____

Parent/Guardian co-signature (required for individuals under the age of 18)

Affiliation – Please Check One Box			
PSHMC Employee ☐	PSU-COM Employee ☐	PSU Employee ☐	Volunteer ☐

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Date: April 2008

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

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College of Medicine

Dress Code Standard

Penn State Milton S. Hershey Medical Center & Penn State College of Medicine For all Student Visitor Programs

The reputation of Penn State Hershey Medical Center and Penn State College of Medicine is influenced by the appearance of its faculty, staff and students. Neat, well-attired and clean appearance creates an atmosphere of confidence, respect and professionalism, which is expected by our patients, families, and colleagues.

There may be specific areas of the hospital and college that have a unique issue that will require additions to this policy. Departments are responsible for developing and maintaining their own specific policies regarding personal appearance. In creating departmental policies, department managers should take into consideration these guidelines when developing their own departmental appearance standards.

For all student visitors, the dress code is recommended as follows:

- Khakis or Dockers
- Casual Shirt
- No Tee Shirts or Halter Tops
- No Jeans
- Close Toed Shoes
    - No Tennis Shoes
    - No Sandals
- No Shorts (for safety and etiquette purposes)
- No Short Skirts (for safety and etiquette purposes)

I have read and agree that I will follow this dress code standard.

_____

Student Signature **Date**

_____

Parent/Guardian Signature **Date**
(If student is under the age of 18)

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

PENNSTATE HERSHEY
College of Medicine

STUDENT/VISITOR WAIVER FORM

Workers' Compensation:
Observer or Student and student's parent(s)/guardian (if applicable) understand and agree that observer/student is not an employee of The Pennsylvania State University and/or Penn State Hershey Medical Center under the terms of this agreement and further understand that observer/student is not entitled to workers' compensation benefits and that observer/student or the student's parent(s)/guardian is responsible for the cost of any medical care or other services that may be required as a result of any injury or illness observer/student may incur while participating in any program in conjunction with this agreement.

Liability:
Observer or Student and student's parent(s)/guardian (if applicable) agree at all times to be responsible for the actions of observer/student in conjunction with this agreement and understand that The Pennsylvania State University and/or Penn State Hershey Medical Center and their employees and agents shall have no liability for the actions of observer/student and further agree to waive all rights of action for any injury or illness that observer/student might incur in conjunction with any activity or program in conjunction with this agreement even if such injury or illness is believed to result from the negligence of The Pennsylvania State University and/or Penn State Hershey Medical Center or their employees or agents.

I acknowledge that I have read and understand all of the above information and agree that during my observer/student experience at The Pennsylvania State University and/or Penn State Hershey Medical Center, I will comply with the above requirements.

_____ _____
Observer/Student Name (Printed) **Date**

_____ _____
Observer/Student Signature **Daytime Phone No. & Email**

If Observer or Student is under the age of 18, a parent or guardian must sign the following: I acknowledge that I have read and understand all of the above information and agree that during my child's student experience at The Pennsylvania State University and/or Penn State Hershey Medical Center, we will comply with the above requirements.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
PSHMC Sponsoring Employee **Department**

_____
Employee Daytime Phone No. & Email

STUDENTS IN AFFILIATED HOSPITAL PROGRAMS, MANDATORY INFECTIOUS DISEASE PREVENTION MEASURES	PENNSTATE HERSHEY Milton S. Hershey Medical Center
Hershey Medical Center – Hospital Administrative Manual	**Policy Number: HR-21HAM**
Replaces: October, 2004	**Effective: February, 2008**
Authorized: Alan Brechbill Executive Director	
Approved: Donna L. Reck, MSN, RN, CNA,BC Chief Nursing Officer	
Approved: Tonya Crook, MD, MS Employee Health Physician	

PURPOSE:

To prevent transmission of infectious disease.

DEFINITION:

STUDENT - Any person enrolled in a program or rotating through a clinical experience/observation where there is potential for patient contact or exposure to any infectious substance.

PATIENT CONTACT - Providing "hands on care" to and including direct observation within a four (4) feet radius of the patient.

DESIGNATED AREAS - Areas where there is potential for exposure to blood, blood products and body fluids.

PROGRAM COORDINATOR - The employee who coordinates schedules, clinical experiences/observations.

POLICY STATEMENT:

Students will comply with the standards of the Employee Health Department and Infection Control Committee.

Matriculated medical and graduate students will comply with these standards through the Student Health Service. Prior to entering the clinical areas, all other students will present to their program coordinator a completed Affiliated Student Infectious Disease Summary form specifying:

1. Documentation of current (within 1 year) tuberculin skin test by Mantoux. If known positive, documentation of chest x-ray (within 2 years) demonstrating absence of disease or documentation of having received Isoniazid prophylaxis therapy.
2. Documentation of positive antibody status to Rubella by laboratory screening or documentation of vaccination against Rubella on or after first birthday.
3. Documentation of positive antibody status to Rubeola by laboratory screening or physician diagnosis of disease, or presenting documentation of vaccination against Rubeola by adequate immunization with two (2) injections of live virus vaccine (at least one month apart) after age twelve (12) months (unless born before 1957).
4. Knowledge of past varicella infection or positive antibody status.
5. Current immunization (within 10 years) for diphtheria and tetanus.
6. For designated areas, it is highly recommended for the students that they have received immunization for Hepatitis B.

There will be no exceptions. Students with incomplete forms may not affiliate at HMC until immunizations are complete.

Compliance to body substance precautions is required while in clinical areas. The student will report any infectious illness or exposure to infectious disease or substances to the work unit manager of the unit where the student is rotating/observing. (NOTE: See Policy: Guidelines for Exposure to and/or Contracting Communicable Disease)

Should an exposure to an infectious disease, blood, blood products or body fluids occur during a clinical rotation, the Employee Health Department will provide an assessment of the exposure (including tuberculin skin test by Mantoux) and the recommendation for follow-up including referral to a health care provider of the student's choice. The student is responsible for his/her own health care and follow-up, HR-17HAM.

PROCEDURE:

1. The program coordinator will forward an alphabetical listing of the names of the affiliated students along with the completed Affiliated Student Infectious Disease Summary form to the Employee Health Department.
2. Once reviewed and approved forms are returned to coordinator to keep on file.
3. After completion of rotation, forms should be returned to student by the coordinator.

POSITION RESPONSIBLE FOR REVIEW & UPDATE:

Employee Health Nurses

Reviewed: 4/98, 10/00, 5/01, 6/03, 10/04, 2/08
Revised: 4/98, 10/00, 5/01, 6/03, 10/04, 2/08

PENNSTATE HERSHEY
Milton S. Hershey Medical Center

Penn State Milton S. Hershey Medical Center
Employee Health Department
AFFILIATED STUDENT/VISITOR INFECTIOUS DISEASE SUMMARY

(In order to participate in a clinical experience/observation in patient care areas it is necessary that the following information be provided and verified by your family physician and/or school nurse)

STUDENT NAME: **BIRTHDATE:**

PHONE NUMBER: **EMAIL ADDRESS:**

AFFILIATING SCHOOL/PROGRAM: **PROGRAM DIRECTOR AND PHONE #**

START DATE AT HMC: **END DATE AT HMC:**
DEPARTMENT: **HMC CONTACT:**

MUST BE COMPLETED BY ALL STUDENTS/VISITORS:

TUBERCULOSIS (PPD) STATUS:

Mantoux Skin Test – Date _____
(must be within 1 year of affiliation)
Results: Negative _____
Positive _____m.m.

IF POSITIVE:
Date of Chest X-Ray _____
(*must be within 2 years*)
Result _____
Isoniazid Prophylaxis Rx
____ NO
____ YES/DATE_____

IMMUNIZATIONS:

Diphtheria/Tetanus – Date _____

Hepatitis B – Date(s) _____
(not required but highly recommended for students affiliated with areas where there is potential for exposure to blood and/or body fluids)

Varicella (Chicken Pox)
Documentation of two (2) doses of vaccine
Dates _____ & _____
OR
Antibody Titre by Lab Screen
Date _____Titre: Positive ___
Negative ___

Rubella (German Measles)
Documentation of two (2) doses of vaccine
Dates _____ & _____
OR
Antibody Titre by Lab Screen
Date _____ Titre: Positive ___
Negative ___

Rubeola (Measles)
(*must be filled out for those born after 1957*)
Documentation of two (2) live doses of vaccine on or after first birthday
Dates _____ & _____
OR
Antibody Titre by Lab Screen
Date _____ Titre: Positive ___
Negative ___

OR

MMR (Measles, Mumps & Rubella)
Documentation of two (2) doses of vaccine
Dates _____ & _____
OR
Antibody Titre by Lab Screen
Date _____ Titre: Positive ___
Negative ___

Signature of Physician or Nurse: _____

Address: _____

Note: Return this form to your Penn State Milton S. Hershey Medical Center departmental point of contact. This document must be approved by the hmc employee health department. Allow one month prior to the student's start date. Non-compliant students may not affiliate at hmc until immunizations are complete. For more info regarding this form (717) 531-8280 (employee health)