UR MEDICINE | THOMPSON HEALTH

Student/Observer Information

Please mark one: ❑ Student Intern ❑ Shadow/Observation

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street) (City/State) (Zip)

Phone #: _____ Cell Phone #: _____

Email Address:_____

School Affiliation: _____

Thompson Associate Preceptor: _____

Beginning Date: _____ Ending Date: _____ Number of Hours*: _____
*Can be estimated if unsure of exact number of hours.

Description of desired duties: _____

_____

Desired department(s): _____

Emergency Contact Information:
Person to Notify in Case of Emergency: _____

Relationship: _____ Phone #: _____

Do you have any impairment that may be of potential risk to the patients, residents, or associates at Thompson Health or that may interfere with your performance of job duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol, or any substance that may alter your behavior?
❑Yes ❑No A yes response will not necessarily lead to any action, although the matter may have to be explored further on a confidential basis. If yes, explain: _____

_____

_____ _____
Signature of Student Signature of Parent/Guardian *(if student is under 18)*

FOR OFFICE USE:

___ Student/Observer Information Form
___ Confidentiality Statement (signed)
___ Health Assessment or Immunization Record
___ Influenza Vaccination Proof or Declination (only required through flu season 10/1-4/1)
___ COVID Vaccine Proof Types and Dates

CONFIDENTIALITY STATEMENT

As a student intern/shadow/observer at Thompson Health, I understand that I will be working with or have access to patient/resident and/or associate information which is confidential. Federal and State statutes and regulations protect the private and confidential nature of patient/resident and/or associate information records.

Moreover, due to the ethical standard of a patient's, resident's and associate's right of privacy, I understand that information I may be exposed to during the course of my work may not be discussed outside the facility or with others within the facility who do not need to know the information for any business or patient/resident care reason.

I understand that anyone with access to patient or other sensitive information through Email, voicemail or our computer system must be keenly aware that this information is highly confidential. Accessing this information will only be done when it is absolutely necessary in order to provide patient/resident care, complete the patient's/resident's medical records or performs the duties necessary to complete my work assignments. Accessing this data must be done with discretion and users must be aware that a record may be maintained for all data accessed. Confidential data should not be copied or transmitted without appropriate approval.

Further, I understand that lack of discretion or unauthorized disclosure of confidential information concerning patients, residents, physicians, volunteers, visitors, fellow associates or Health System business is considered a major infraction of health system policy and may lead to disciplinary action, up to and including termination.

_____	_____
Signature	Signature of Parent/Guardian *(if under 18)*
_____	_____
Print Name	Parent/Guardian Print Name
_____	_____
Date	Date

cc: File

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STUDENT CONFIDENTIAL HEALTH ASSESSMENT

(This form may be substituted with an immunization record documenting all requirements.)

The New York State Department of Health requires anyone working in a health care facility to meet certain requirements before starting. This includes student interns as well as all associates. Please take this form to your physician's office for a signature and for any information he/she has to document the tests/vaccines below. The completed form must be returned to Thompson's Associate Health Office. If you have any questions, please call the Associate Health Nurse at 585-396-6655.

My patient,_____, has

1. Received two TB skin tests. First test can be within the last 12 months. Second test **MUST** be within a minimum of 1-4 weeks prior to the start date. QuantiFERON gold must be within 30 days prior to start.

   First test date:_____ Date Read:_____ Result:_____

   Second test date:_____ Date Read:_____ Result: _____

   OR

   Has a history of a positive skin test in _____ (year) _____

   A chest x-ray was performed on _____ Results _____

   A QuantiFERON-TB Gold obtained on_____ Results _____

2. Proven immunity to German Measles (Rubella) by one of the following:
   a. One dose of Rubella/MMR vaccine-date: _____
   b. Serologic proof-date: _____Result:_____

3. Proven immunity to Measles/Rubeola (if born after 1956) by one of the following:
   a. Two doses of Rubeola/MMR vaccine-dates:_____
   b. Serologic proof-date: _____Result:_____

4. Proven immunity to Varicella (Chickenpox) by one of the following:
   a. Varicella Vaccine-date (s): _____
   b. History of disease: _____
   c. Serologic proof-date: _____Result:_____
   d. Signed Declination: Declination is attached, complete and return with forms.

5. Flu Vaccine by one of the following:
   a. Most recent Influenza Vaccine-date:_____
   b. Signed Declination: Declination is attached, complete and return with forms.

6. Covid Vaccine Indicate Type and Date:
   a. Dose 1: (Pfizer/Moderna/Janssen/Other) date:_____
   b. Dose 2: (Pfizer/Moderna/Janssen/Other) date:_____
   c. Booster(s): (Pfizer/Moderna/Janssen/Other) date:_____
   d. Signed Declination: Declination is attached, complete and return with forms.

Been examined by me and is physically and mentally able to work/volunteer at Thompson Health.

Date: _____ Physician's Name: _____ Physicians License #:_____

Address: _____

Phone Number:_____

Physician's Signature: _____