CULLMAN
REGIONAL

Single Signature Form
Clinical/Non-employee- (Patient Contact)

Affiliation: (College, Contract Co. etc.):_____

Department Clinical Rotation Site (Please check as appropriate)

Nursing (All)		*DI-Radiology*		*Pharmacy*		*EMS (All)*	
Respiratory		*DI-Ultrasound*		*Home Health/Hospice*		*Emergency Room*	
Lab-Phlebotomy		*DI-Nuclear Med*		*One Fitness*		*Speech Therapy*	
Lab- Techs		*Neuro-EEG*		*Nutritional Therapy*		*Case Management*	
Rehab- OT – OTA		*Sleep Center*		*CPCA Program*		*Surgery*	
Rehab- PT – PTA		*CPAP*		*Scrub Tech*		*Central Sterile Tech*	
Other(fill in):							

Rotation Dates: _____/_____/ _____to_____/_____/_____

Statement of Comprehension

Confidentiality is a basic element of the operation of Cullman Regional. Release or use of any employee, patient customer, resident or other company information is a violation of policy including release or use for personal benefit.

The care and treatment of customers / patients are highly personal in nature. All individuals allowed in the patient care areas have ***a legal obligation*** to ensure that all medical information or personal matters will be kept strictly confidential. This information will be discussed with authorized personnel directly involved in the care and treatment on a ***"need to know - minimum necessary rule".***

Protected Health Information, or PHI, is any patient information – whether it is spoken, written, or on the computer. Confidential information includes any medical information relating to patient care - including, but not limited to, Protected Health Information - privacy information - including, but not limited to dates of birth and social security numbers for patients - and confidential business information - including, but not limited to billing practices, accounting information, human resources information or information from other administrative areas.

I understand that user identification codes assigned to me are to be used solely by me and passwords are not to be shared. I will not allow anyone to use my user ID for any reason. I am responsible for any and all activity recorded under my user ID. It is my responsibility to log off once I have completed my tasks. I will immediately report any known or suspected unauthorized access, use or disclosure of PHI.

I understand it is prohibited to take photos in patient care areas, of patients or post photos and any information obtained while at Cullman Regional on social media.

I understand that I am responsible and legally bound to comply with strict compliance, all privacy and confidentiality requirements, policies and procedures, including the privacy and security of confidential information obtained during my visit at all times, whether I am off-campus or within facilities.

Student Verification

Medication Administration Disclaimer

I understand that as a student I am NOT allowed to dispense / administer medication in any form without the supervision of a licensed Cullman Regional employee or a licensed clinical instructor from the college I am attending. I understand that dispensing medications while unsupervised as a student is practicing without a license. I also understand that if I dispense or administer medications while unsupervised this will result in my privileges as a student being revoked immediately.

If as a student you will not have a reason to give medication then please check non-applicable here and sign below. ☐

I verify that I have read and understand the information presented in Hospital Orientation Packet. I have been given the opportunity to clarify any part of the information I may have questions/concerns about. I understand the expectations of Cullman Regional and agree to abide by its policies, procedures, requirements, and practices during my assignment here.

I acknowledge Cullman Regional's Confidentiality statement and that it is my responsibility to become familiar with the information regarding Confidentiality / HIPAA. I also understand that it is my responsibility to consult my instructor, the department director (or designee) if I have any questions regarding policies and / or procedures during my visit at Cullman Regional.

Print Name: _____ **Sign Name:** _____

Date: _____/_____/_____ **Phone Number:** _____

Instructor verification (instructor only)

By signing below I verify that the students listed have had: a drug screen, a background check, a TB skin test; all of which were negative without discrepancy, and a physical exam that shows him/her to be able to perform in a clinical setting without limitations. The student has completed the orientation packet. I also understand that while practicing as a student at Cullman Regional they will not be allowed to dispense/administer medication unsupervised while at bedside.

Please Verify Below:

Student has:

- ✓ on file records for immunity to rubella, mumps, measles, pertussis, and chicken pox.
- ✓ proof of health and liability insurance.
- ✓ current CPR card that will not expire during clinical rotation (as applicable).
- ✓ Flu Vaccine – mandatory for any student rotating clinical at Cullman Regional applicable during the months of (October through March unless otherwise extended) or student MUST wear mask within 6 feet of patient.

Program Director/Designee Verification/Witness:

Print Name: _____ **Sign Name:** _____

Date: _____/_____/_____ **Phone Number:** _____

Revised/Reviewed: PDE: 08/2011; 02/2013; 02/2014; 03/2015; 03/2015; 01/2018; 08/2018; 01/2020