Student Checklist

School and Program_____

Student's Name Please Print	Date Reviewed	Student Initials
1. I have read all the information presented in the Student Checklist and Orientation Manual, visited all the websites listed and understand all information provided.		
2. I have read and agree to adhere to the conditions of the Confidentiality Agreement and HIPPA Privacy, Security and Confidentiality Agreement provided in the Student Checklist and Orientation Manual.		
3. I have read the Conflict of Interest statement within this packet. I agree to safeguard the confidentiality of all information that I have access to in the course of my time at the Community Medical Center and to use proper procedures when required to release such information to others. I also agree to disclose to the Community Medical Center any conflict of interest I may have. I understand that failure to do so may result in disciplinary action, up to and including termination of the clinical experience.		
4. I understand that in the event that I sustain an injury or have an accident during clinical experiences, I will receive emergency treatment if needed. I understand my health insurance will be billed for any necessary treatment and any balance will be billed to me. It is recommended that I carry personal health insurance. The responsibility for follow-up care remains with me.		
• I reviewed the drug screen section of the Student Checklist and Orientation Manual. I am verifying that the information on my 10 panel drug screen is no more than **30 days** from the start of the school year; I am verifying that the results show no discrepancies		
6.. I have reviewed the Background Check section of the Student Checklist and Orientation Manual. I am verifying the records are clear with no hits. I understand that I must report to my school and the Community Medical Center designated contact, within 48 hours, any criminal charges, arrests or indictments that occur at any time during my rotations. I also understand that I must report any criminal charges, arrests or indictments that have occurred since the background check was provided, to the school and the COMMUNITY MEDICAL CENTER designated contact before I can begin my rotation. Failure to do so could lead to termination of the clinical experience.		
7. I acknowledge that I have received instruction on accessing the POLICIES & PROCEDURES for the COMMUNITY MEDICAL CENTER. I agree that if there is any policy or provision in these documents that I do not understand, I will seek clarification from the Human Resources department and/or the nursing staff. In addition, I understand that these resources state the COMMUNITY MEDICAL CENTER policies and practices in effect on the date of publication. I understand that nothing contained in these documents may be construed as creating a promise of a binding contract with the COMMUNITY MEDICAL CENTER for any purpose. I also understand that these policies and procedures are continually evaluated and may be amended, modified, or terminated at any time. I expressly agree to be bound by the policies and guidelines outlined, as well as future modifications to such policies and guidelines.		
7. Proof of Current Immunizations: See Guidelines on page 8 of the Student Checklist and Orientation Manual. Immunization records are to be kept and maintained by the school. Records are not to be submitted to the COMMUNITY MEDICAL CENTER. By signing, I am verifying that the information on file with the school is accurate and current. I also understand that I, as the student, am responsible for keeping these records current.		

Student Signature_____ Date_____