Background /Sexual Offender Check Release Authorization

In connection with my application for participation in clinical rotations at Community Medical Center, Kalispell Regional Healthcare, North Valley Hospital and/or St. Patrick Hospital, hereafter referred to as ORGANIZATIONS, and as a condition of acceptance at these ORGANIZATIONS for such rotations, I voluntarily agree that the ORGANIZATIONS, its agents or designees, may request and obtain one or more background checks regarding me; including criminal background check, exclusion database lists and national sexual offender lists; and the information received from the background checks may be shared between these ORGANIZATIONS and my school. The ORGANIZATIONS can also receive and use for its purposes any such background checks from the school.

I hereby authorize and release from all liability, without reservation, the ORGANIZATIONS and my school, and its agents and employees, as well as any law enforcement agency, local, state or federal government agency, institution, information service bureau, or any other person or entity, from liability for requesting, conducting, receiving and communicating the above information.

I further acknowledge that a telephone facsimile (fax), photographic or digital (pdf) copy of this executed release will be as valid as the original.

I understand that I must report to the ORGANIZATION designee, within 48 hours, any criminal charges, arrests or indictments that occur at any time during my rotations at these ORGANIZATIONS. I also understand that I must report any criminal charges, arrests or indictments that have occurred after the background check that was cleared on _____/_____/_____ to the ORGANIZATIONS designee before I can begin my rotation.
Date Background Check Information Was Cleared
Failure to do so could lead to termination of the relationship. This reported information may also be shared with my school.

Print Name_____
Last First Middle

Maiden/Previous Name(s) (if applicable) _____

Name of School_____

Program _____ Date of Birth_____

Signature_____ Date Signed_____

*******To be completed by approved school/facility representative or ORGANIZATION only*******

The cleared records for the background check, exclusion database lists and national sexual offender lists are to be kept and maintained by the school or facility unless prior arrangements have been made. Records are not to be submitted to the ORGANIZATION unless approved in advance by the ORGANIZATION. By signing below, I am verifying that this information is on file with the ORGANIZATION, facility, and school and/or university system. If requested, we will provide these documents to the ORGANIZATION within one business day of the request. I am verifying the records are clear with no records or discrepancies.

School/Facility or ORGANIZATION Representative Signature	Date
Print Name	Title
Phone Number	Email address

Updated 3.5.2013

COMMUNITY MEDICAL CENTER

From day one.

Student CERNER Access Request Form

Please submit one form per student group to the Education Department, voa e-mail
Please allow two weeks for processing

Educational Institution: _____

Student Educational Level (e.g. Sophomore, Junior– 1st or 2nd semester/quarter): _____

Have these students had access to CERNER, as nursing students, at CMC before? Yes ☐ No ☐

Mixed Group ☐ (indicate which students have had previous CERNER access next to their name below)

Instructor(s)' Name: _____

Instructor(s)' Email: _____

Instructor(s)' Phone: _____

Has the instructor(s) had access to CERNER at CMC before? Yes ☐ No ☐ Mixed ☐ (indicate above)

Where will the students be completing their clinical rotations (e.g. Med/Surg): _____

What is the first day of clinical rotation at CMC? _____

What is the last day of clinical rotation at CMC? _____

List preferred dates/times for student CERNER Orientation: _____

List all of your student names below:

(Please note: If you have more than 12 students, they will need to be broken into two groups. We can only accommodate 12 students per training session)

Group #1 *Please incude a middle initial*	**Previous CERNER Access**	**Group #2** *Please incude a middle initial*	**Previous CERNER Access**

Please answer the additional questions below to help the CERNER Trainers tailor your student's orientation to their educational needs:

1. What are your student's requirements for their orientation? (Please elaborate)

2. Do your students take their own patient assignments?

3. Do they chart assessments?

4. Do they give meds?

5. Do they write care plans as part of a class requirement?

6. Any additional comments?

****Please note, this form is required to be completed in its entirety before your students will be scheduled for CERNER Orientation****

Return all completed forms to Melissa Bailey
Student Onboarding Coordinaor

mbailey@communitymed.org

Form Last Updated: 11/2022

COMMUNITY MEDICAL CENTER
From day one.

School Checklist/Requirement Verification

Student's Name _____ Student's Phone # _____

Student's Email _____ School/Program: _____

Rotation(s): _____

Start Date: _____ End Date: _____

This form is to be completed by an authorized school representative.

	School Representative Initials
1. **Immunizations:** I am verifying that the information required on the student's immunization verification form is on file with the school. If the school has made other arrangements to have the student supply immunization records directly to the ORGANIZATION, please check here. ☐	
2. **Background Check**: I verify that a criminal background check, exclusion list check from Office of Inspector General (OIG) http://exclusions.oig.hhs.gov/ and national sexual offender registry search http://www.nsopw.gov/en-us has been completed on this student. I am verifying that the results show no records and/or no discrepancies.	
3. Drug Screen: I am verifying that the information on the student's 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	
4. Letter of good standing and proof of professional liability for the student while rotating at ORGANIZATION will be provided prior to the start date of the clinical rotation(s).	
5. I verify the above statements to be true. I have reviewed and understand all the information that has been given to the students in the Student Checklist and Orientation Manual.	

Authorized School Rep Signature_____ Date _____

Print Name _____Phone # _____

Email address_____

COMMUNITY MEDICAL CENTER
From day one.

TUBERCULOSIS SCREENING QUESTIONNAIRE FORM

SECTION 1: INFORMATION/CONSENT

Mycobacterium tuberculosis (TB) is a disease which is carried through the air in small particles when people, who have active TB cough, sneeze, speak, or sing. It usually affects the lungs but can also affect the heart, kidneys, bones, and other organs of the body. The TUBERCULOSIS SKIN TEST (TST) is a way of identifying TB infection. You cannot get TB from the skin test. Health care workers are required to be screened regularly for TB. Depending on where you work, you may need to have annual TB skin test.

SIDE EFFECTS:
If you have been exposed to TB in the past, swelling and redness may develop at the site of the test. A blister or scar may also result.

PRECAUTIONS:
The TB skin test **should not be given to persons who have had a positive reaction in the past**, or who have had an active case of TB, or who have taken TB medications in the past. If this has happened to you, please tell the nurses prior to taking the skin test.

If you have any questions or do not understand this information, please discuss this with the nurse now.

If you get a TB skin test, you MUST return to have your test read in 48 to 72 hours. Failure to have the test read will necessitate repeating the test.

SECTION 2: RISK ASSESSMENT *Please Circle Y" for Yes and "N" for No*

Have you ever had a **POSITIVE** reaction to a TB skin test? When? _____ Date of Last Chest x-ray? _____	**Y**	**N**
Have you ever had/been treated for, Tuberculosis? **When?** _____	**Y**	**N**
Have you had a ***KNOWN*** exposure to someone with ***ACTIVE*** Tuberculosis since your last TB Skin Test? **Who?** _____ **When?** _____	**Y**	**N**
Have you ever had an allergic reaction to a TB skin test? **Describe?** _____	**Y**	**N**
Have you been immunized against TB with BCG vaccine? (Common for those born in foreign countries)	**Y**	**N**
Have you had **Any** vaccines in the past **4 weeks?** **What vaccine:** _____ **When:** _____	**Y**	**N**

Have you had temporary or permanent residence of ≥ 1 month in a country with high TB rates? Any country other than the U.S., Canada, Australia, New Zealand and those in Northern Europe or Western Europe	**Y**	**N**
Current or planned immunosuppression?	**Y**	**N**
Close contact with someone who has had infectious TB disease since your last TB test?	**Y**	**N**
Do you have any of the following Tuberculosis symptoms:		
Persistent cough for longer than 2 weeks	**Y**	**N**
Coughing up blood	**Y**	**N**
Profuse night sweats	**Y**	**N**
Recurring, dull, tightness or aching pain in chest	**Y**	**N**
Loss of appetite	**Y**	**N**
Unexplained weight loss	**Y**	**N**
Chills and/or fever	**Y**	**N**
Extreme fatigue	**Y**	**N**

I have read and understand the above information on this form about tuberculosis skin testing. To the best of my knowledge the above answers are true. I give my consent to have the tuberculosis skin test.

Name (print):_____ **Signature:** _____

Department: _____ **Job Title:** _____

COMMUNITY MEDICAL CENTER
From day one.

Immunization Verification Form

Approved School Representative or Student Coordinator Use Only

Name of Student_____ **School**_____
Please Print

Please insert dates and check boxes below as applicable. **Current**

COVID-19 Vaccine **Yes☐ No☐**

Pfizer 1st dose date 1 ___/___/___ Pfizer 2nd dose date___/___/___ Pfizer booster dose date_____
Moderna 1st dose date 1 ___/___/___ Moderna 2nd dose date___/___/___ Moderna booster dose date_____
Johnson & Johnson immunization date ___/___/___

MMR (measles, mumps, rubella) **Yes☐ No☐**

MMR Record 1 ___/___/___
Record 2 ___/___/___
Use below **only** if measles, mumps and rubella vaccinations were administered separately.
Measles ___/___/___, mumps___/___/___, rubella___/___/___
Measles ___/___/___, mumps___/___/___, rubella___/___/___
OR
Positive titer dates for Measles ___/___/___, mumps___/___/___, and rubella___/___/___

Varicella (chickenpox) **Yes☐ No☐**

Vaccination dates___/___/___AND ___/___/___(two recommended by the CDC)
OR titer date___/___/___**OR** recollection of having the disease _____
(Year or age had disease)

Hepatitis B **Yes☐ No☐**

Record 1___/___/___Record 2___/___/___Record3___/___/___**and** positive Titer date ___/___/___
OR Can be declined but student must sign a declination. Date signed___/___/___

Tetanus w/ Pertussis (Tdap) ***Note this must be Tdap not TD or DPT*** **Yes☐ No☐**

Date shot received___/___/___

Record of current flu shot **Fill in dates vaccinations were administered for every year the student is in clinical rotations.**

First Year	
Second Year	
Third Year	
Fourth Year	

TB (PPD-tuberculosis) Record of a negative TB test within the last twelve months or a negative Quantiferon TB test is required. Or fill out Positive Responder Form. Ask Community Medical Center for this form if you have a positive test. AND each year a student attends the same program they must fill out a TB questionnaire provided by the COMMUNITY MEDICAL CENTER. This questionnaire will then be sent to Community Medical Center' appropriate department along with a copy of the original negative TB test to be reviewed and a determination will be made by that department if an additional test is necessary based on the risk factors stated in the questionnaire

Date of First Negative TB Test Results	Returning Student Annual TB Questionnaire Signed Date	ORGNAIZATION Approval Date for Questionnaire	Date of Negative Quantiferon

Proof of this information is to be kept and maintained by the school unless other arrangements have been made with the ORGANIZATION. Actual immunization records are not to be submitted to the ORGANIZATION unless prior arrangements have been made. By signing below, I am verifying that proof of this information is on file with the school or facility or the records have been submitted to the ORGANIZATION. If requested, we will provide these documents to the ORGANIZATION within one business day of the request for random audits. The school will be responsible to keep these records up to date and inform the student in advance when an immunization expiration date is approaching.

School Representative Signature _____ Date _____

Print Name _____ Title _____

Phone Number _____ Email address _____

Updated 08/24/2021