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_____

Exhibit B
CONFIDENTIALITY STATEMENT

The undersigned hereby acknowledges his or her responsibility under applicable Federal law and the Agreement between _____ (School) and **RCHP Billings-Missoula, LLC d/b/a Community Medical Center** to keep confidential any information regarding Hospital patients, as well as all confidential information of Hospital. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Hospital, except as required by law or as authorized by Hospital.

Date: _____, 20_____

_____
Program Participant Signature

_____
Program Participant Name (Please Print)

Exhibit A
STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided the undersigned in the form of experience in evaluation and treatment of patients of **RCHP Billings-Missoula, LLC d/b/a Community Medical Center** ("Hospital"), the undersigned and his or her heirs, successors and assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the Program operated by _____ ("School") at Hospital unless such injury or loss arises solely out of Hospital's gross negligence or willful misconduct.

Date: _____, 20_____

_____ _____

Program Participant Signature | Witness

Print Name: _____ | Print Name: _____