	Medical Student , PA, and NP Clinical Students Requirements	
	Per Agreement and/or Policies	
	Required documentation:	
1	Signed Letter of Agreement between School and Novant Health and current Certificate of Insurance (verify on file)	☐
2	Signed Confidentiality Agreement (Non-Employed Worker packet)	☐
3	Signed Orientation/Compliance Roster (Non-Employed Worker packet)	☐
4	Signed Tobacco Free Form (Non-Employed Worker packet)	☐
5	Signed Education Experience Agreement	☐
6	Faculty/Student/School Information Contact Sheet	☐
7	Employee ID Badge Request (Non Credentialed) Form	☐
8	Employee Parking Permit Form	☐
9	FOR SURGERY and OB/GYN ROTATIONS ONLY:	
	Schedule OR Training/Scrub validation class (email request to Surgical Services Educator for that area. This must be completed prior to rotation.	
	To schedule scrub skills validation:	
	Choose your facility from the drop down box.:	
	NHFMC, NHMPH, NHKMC, NHCMC, NHFOSC, NHHOSC, avhawks@novanthealth.org	
10	Scrub Suit Access Request Form	☐
11	**Training Modules Signed Certificate of Completion:**	
	Medication Safety Module	☐
12	Immunization record (birth to present).	
	MMR #1 #2 **or Titer Rubeola, Rubella, and Mumps**	
	Varicella #1 #2 **or Titer Varicella**	

	TB/PPD #1 #2 within the last 12 months	
	Hepatitis B (HepB) #1 #2 #3 **or Titer**	
	DPT #1 #2 #3 **or Tdap**	
	Flu Vaccine (October-March)	
13	Criminal Background check (nationwide SS# trace, OIG, Sex Offender Register)	☐
14	Drug Screen (12 panel)	
	<u>12-panel drug screen</u>	
	1)AMP amphetamine 2)BAR barbiturates 3)BZP benzodiazepines	
	4)COC cocaine 5)MDMA ecstasy 6)METH methamphetamines	
	7)MTD methadone 8)OPI opiates 9)OXY oxycodone	
	10)PCP phencyclidine 11)PPX propoxyphene 12)THC marijuana	
	Students, Please submit this check list as well as the above documents to your school professor/advisor to submit to the hospital designee.	

Type in information and save to your computer.
Then submit electronically to Instructor/Advisor

Student/School/Faculty Information Sheet

Student Information:

Date:	
Name (enter first, middle & last):	
Address:	
Telephone #	Email
Date of Birth:	
Last 4 SSN/ID	Nursing License # if applicable:
Liability Insurance Carrier: If provided by school leave blank	
Have you ever been employed by Novant Health?	Yes ☐ No ☐

Educational Facility:

Educational Facility:	
Educational Program:	Graduation Date:
Supervising Faculty:	
Faculty Email Address:	
Rotation Service/Course Name:	
Rotation Dates:	Start Date End Date
Total number of Hours	

Rotation Facilities:

Select the primary Novant Health facility where you most likely will be rotating:

Brunswick Medical Center

Select the secondary Novant Health facility where you may be rotating:

Brunswick Medical Center

If NHMG specify practice:

Dimensions training completed (check all that apply): ◯ Amb ◯ Acute IP ◯ OB/GYN ◯ ED ◯ Surgery ◯ View Only ◯ none	◯ Rotation in Practice only ◯ Rotation in Acute Care Facility only ◯ Rotation in Practice and Acute Care

Supervising Physician/Preceptor:

Preceptor's Name:	
Preceptor's email address:	
Preceptor's Telephone #:	
Supervising Physician/ Preceptor's Office Address:	

EDUCATION EXPERIENCE AGREEMENT

Novant Health (Novant) allows certain students ("Students") to participate in education experiences in Novant facilities in an effort to assist the student in achieving educational objectives. In order to protect the safety and welfare of the patients and employees, as well as myself, I agree as follows:

- I will fulfill the responsibilities assigned to me by the Facility during the clinical training program. I agree to comply with Facility's rules, regulations and policies.
- I will follow the *Faculty and Student Dress Code* and will wear an Identification Badge prominently at all times during my education experience.
- I will be on time. I will remember to bring money for lunch and parking fees.
- I will treat patients, visitors, employees, and physicians with respect. Patients have the right to refuse to allow me to participate and/or observe their care and I will honor that.
- I will cooperate with Novant staff in arranging the dates, times, and length of my education experience.
- I will follow the *Confidentiality Agreement* and hold all information I learn about patients in strict confidence.
- I will follow the direction of my preceptor and remain with her/him at all times.
- I will work with my preceptor and others to make sure that my education experience is meaningful.
- I will observe proper hand hygiene and other infection control measures.
- In the event I am involved in an accident on Novant property and need help, Novant will provide access to first aid or emergency care. If I am seen in the Emergency Department, I will be charged normal Emergency Department fees.
- I am responsible for my own actions while I am participating in the education experience, including any negligent or intentional acts that may result in a claim against a Novant employee or facility.
- I will not make or receive personal calls and/or text messages during the workday, regardless of the phone used, may result in the student being removed from the facility. Please leave your cell phone with your personal belongings. You may make personal calls and send text messages on non-work time (breaks, lunch, etc). Please make sure that your friends and family members are aware they should not call during the workday unless it is an emergency.
- I authorize Novant and my educational institution to exchange a copy of my records, including health and immunization records.
- In the event that I am employed by Novant, apply for employment at Novant or provide services in any capacity to Novant outside the scope of this clinical training program, I authorize Novant to disclose the results of my Criminal Background Check, Office of Inspector General Report, Drug Screen and any other information related to my performance during this experience to Novant Health's Human Resources Department and Employee Occupational Health Department if the results of those reports would disqualify me or otherwise impact my employment or other relationship.

Print Name of School	
	Date:
Student Signature	
Student Printed Name	
	Date:
Instructor/Advisor Signature	

Instructor/Advisor Printed Name

Novant Health Employee ID Badge Request (Non-Credentialed)

EMPLOYEE INFORMATION:

Employee Full Name:		**Preferred Name:**
Employee #:	**Department Name :**	**Dept #:**
Facility/Location:		
Credential #1:	**Credential #2:**	**(for verification purposes only)***

By signing below, I verify that all information noted for badge request is correct and accurate. I understand that any falsification of information or misuse of my ID badge for identification purposes or to gain access for reasons other than to fulfill my job duties may lead to disciplinary action up to termination.

*** I also understand that Public Safety cannot make any changes to credentials, names, and employee #'s in the PeopleSoft system and this data must be updated by the employee's direct report or HR.**

If this is a replacement ID badge, I understand that I maybe charged $15.00 depending on the purpose for the ID replacement. All payments can be made to either the hospital cashier's office or Public Safety office directly. A receipt for proof of payment will be required prior to receiving my new badge ID if paid through hospital cashier's office.

Employee Signature:

Date:

AUTHORIZATION:

Department Manager/Supervisor (Please Print):

Signature Department Manager/Supervisor: **Date:**

Public Safety Representative: (Please Print):

All Novant ID badges must be picked up @ either your local Public Safety department or from your direct manage/director or proxy. Please make sure to bring a Photo ID with you when picking up your ID badge.

NOVANT HEALTH

Scrub Suit Size Survey

User Last Name: _____

User First Name: _____

Employee #:
6 digit number on the back of the ID badge
(Leave blank if you do not have your badge)
_____

Phone #: _____

Male ☐ Female ☐

Personal Identification Number
PIN – 4 Digits
(If not completed, a PIN will be assigned) ☐ ☐ ☐ ☐

Please choose one of the following for Occupation and one for department:

Occupation:

- ☐ Medical Student
- ☐ NP/PA Student
- ☐

Department:

- ☐ Women's Services
- ☐ PACU
- ☐ NICU
- ☐ ED
- ☐ OR
- ☐ Other (Specify)_____

Sizes - Choose your appropriate size combination:

Top ☐ Small ☐ Medium ☐ Large ☐ XL ☐ 2X ☐ 3X ☐ 4X ☐ 5X

Pant ☐ Small ☐ Medium ☐ Large ☐ XL ☐ 2X ☐ 3X ☐ 4X ☐ 5X

Please return to Glenda Livengood, Director of Student Programs,
Fax: 336-277-6986 Phone: 336-718-6082