



**MEDICAL STAFF-SPONSORED
STUDENT APPLICATION**

Phone 303-415-7490 • Fax 303-415-7498 • Email medstaff@bch.org

Complete Name of Applicant: _____

Social Security Number: _____ Date of Birth: _____

Complete Address: _____

Phone: _____ E-Mail: _____

Name of School: _____

(Residency, Medical, Technical Training)

Complete Address: _____

Dates of Training: _____

Name of Sponsoring Medical Staff Member: _____

Dates of Rotation at BCH: _____ (not to exceed 90 days)

Submit documentation of all of the following. Incomplete documentation will not be considered.

- 1. Signed Application – 3pp, signed on p 2, 3 and 4 by both the student and sponsoring practitioner(s)
- 2. HIPAA Form – Page 4 of this application. Include Sponsoring practitioner’s signature.
- 3. Letter of current status– from training program
- 4. Professional Liability Insurance– with limits of liability of at least \$1m/\$3m
- 5. Comprehensive criminal background check– recently performed by training program with verification of eligibility to participate in federal health programs
- 6. Drug screen – recent negative results
- 7. Health requirements as required in Student Agreement:
 - a. Rubella –Titer of 1:10 (or immune) per laboratory finding, or two vaccines on or after age 12 months;
 - b. Measles/Rubeola – Positive rubeola titer or two doses of live vaccine given after the age of 15 months for individuals born after 1956, given at least 30 days apart or serologic evidence of immunity (individuals born prior to 1957 are assumed immune);
 - c. PPD– negative test result within the last year or a negative chest film in the last two years;
 - d. Hepatitis B– Three vaccines or serologic proof of immunity; and
 - e. Influenza– vaccination during influenza season (November - March).



Student Acknowledgement

I understand that the procedures requested may differ from those approved, and I will only perform those procedures approved and with the immediate supervision of my medical staff sponsor and/or their credentialed designees as delineated by statute in the state of Colorado. I understand that students **may not document in the patient's chart without specific prior authorization. If authorized, my sponsor must countersign progress notes before they are valid, and that students MAY NOT write orders.**

In making application for sponsored student activities at Boulder Community Health (BCH), I agree to abide by the Medical Staff Sponsor Agreement attached hereto and incorporated in this application, the Medical Staff Bylaws, Rules and Regulations and Hospital Policies and Procedures. I fully understand that any significant misstatements in, or omissions from this application may constitute cause for termination of my status as a sponsored student.

I attest that I have received HIPAA/Compliance training. I acknowledge that I may encounter patient information and other information that is considered strictly confidential and is protected from disclosure by both state and federal laws. By signing this application, I assure BCH and the medical staff that I will maintain the confidentiality of all information that comes into my possession during the course of my student activities at BCH, and I shall not divulge any such information at any time.

Signature of Applicant: _____ Date: _____

Medical Staff Sponsor Agreement

As the Medical Staff member ("Sponsor") responsible for the student and as an active member of the medical staff of Boulder Community Health (BCH), I have evaluated and attest to the competency of the student to perform the requested procedures and I agree to immediately supervise the student in performance of the delineated procedures, to assure optimal patient safety at all times. Further, I agree to provide appropriate monitoring of the student adherence to the scope of approved procedures. I agree to ensure that the student complies with all applicable laws and rules, regulations, policies and procedures and practices in a safe, competent and non-disruptive manner at BCH.

If the student's insurance coverage under her/his training program is less than the amount or type of coverage required for medical staff members, I further agree to indemnify BCH and the medical staff for all acts and omissions of the student while he/she is performing student activities at BCH. In the event I am sponsoring students as a part of my job duties as an employee of a governmental entity, I agree to provide verification to BCH that I am covered under the Colorado Governmental Immunity Act for my conduct in sponsoring the students, and further agree that the foregoing shall not apply and that Student, BCH and myself, subject to the limitations of the Governmental Immunity Act as applicable, shall each be responsible for our own conduct, acts and omissions.

Signature of Medical Staff Sponsor: _____ Date: _____

Rotation dates: _____ **to** _____ **– (not to exceed 90 days)**

Delineation of Procedures

Name of Applicant: _____ Field of study: _____

✓ **Indicate specific procedures you wish to perform:**

Medical:		Surgical: REQUIRED: You must submit evidence of sterile field and proper gowning techniques with your initial application. You must complete an orientation with the surgery educator before entering the OR.	
<input type="checkbox"/>	History/Physical examination (May not become part of the permanent legal patient record or dictated on the hospital system)	<input type="checkbox"/>	Assist with patient positioning/draping
<input type="checkbox"/>	Patient education	<input type="checkbox"/>	Assist with clipping and marking
<input type="checkbox"/>	Assist with patient plan of care	<input type="checkbox"/>	Pass surgical instruments from mayo
<input type="checkbox"/>	Assist with patient discharge planning	<input type="checkbox"/>	Handle suction and/or sponge surgical field
<input type="checkbox"/>	Rounds	<input type="checkbox"/>	Retract
<input type="checkbox"/>	Assist with skin testing, including performance and reading	<input type="checkbox"/>	Assist surgeon in utilizing special equipment
<input type="checkbox"/>	Assist with taking of cultures	<input type="checkbox"/>	Break down surgical field, deliver instruments for reprocessing
<input type="checkbox"/>	Assist with urinary/Bladder catheterization	<input type="checkbox"/>	Assist with anterior nasal packing for epistaxis
<input type="checkbox"/>	Assist with nasogastric intubation	<input type="checkbox"/>	Assist with excision fulguration of simple skin lesion
<input type="checkbox"/>	Assist with gastric Lavage	<input type="checkbox"/>	Assist with I & D of superficial skin infection
<input type="checkbox"/>	Injections	<input type="checkbox"/>	Assess, dress & bandage superficial wounds
<input type="checkbox"/>	Venipuncture	<input type="checkbox"/>	Assist with debridement
<input type="checkbox"/>	Arterial puncture (blood Gases)	<input type="checkbox"/>	Assist with suture/removal of sutures
<input type="checkbox"/>	Assist with flex/sig	<input type="checkbox"/>	Assist with removal of foreign body from exterior surface
Obstetrical (Limited to Medical and CNM students)		<input type="checkbox"/>	Assist with removal of impacted cerumen
		<input type="checkbox"/>	Assist with insertion/removal of drains
		<input type="checkbox"/>	Assist with dressing changes
<input type="checkbox"/>	Assist with assessment of pregnant women	<input type="checkbox"/>	Assist with Application of traction
<input type="checkbox"/>	Assist with assessment of fetal/neonate well being	<input type="checkbox"/>	Assist with sprains including strapping and splinting
<input type="checkbox"/>	Assist with sterile vaginal exam	<input type="checkbox"/>	Assist with casting, including application and removal
<input type="checkbox"/>	Assist with diagnostic vaginal testing	<input type="checkbox"/>	Assist with urinary and bladder catheterization
<input type="checkbox"/>	Assist with ultrasound	<input type="checkbox"/>	Manage MAC, general and regional anesthetics; including but not limited to airway management as well as invasive and non-invasive monitoring
<input type="checkbox"/>	Assist with use of internal scalp electrodes		
<input type="checkbox"/>	Assist with intrauterine pressure catheters		
<input type="checkbox"/>	Assist with normal spontaneous vaginal delivery of baby and placenta	IMPORTANT NOTE:	
<input type="checkbox"/>	Assist with assessment and repair of first and second degree vaginal and perineal lacerations	<ul style="list-style-type: none"> • STUDENTS ARE NOT ALLOWED TO DOCUMENT IN THE PATIENT'S CHART, ACCESS IS PURELY FOR EDUCATIONAL PURPOSES • STUDENTS MUST WEAR SCHOOL BADGE FOR IDENTIFICATION 	
<input type="checkbox"/>	Assist with episiotomy repair		

I hereby request the authority to perform the procedures identified above which I am in training to perform; I understand that the procedures requested may differ from those finally approved. I affirm that I will not perform any procedures without the immediate supervision of my medical staff sponsor and/or their credentialed designee as delineated by statute in the state of Colorado. I further agree to perform all procedures in accordance with the Medical Staff-Sponsored Student Agreement, which I have executed as part of my application.

Signature of Applicant: _____

Date: _____

Signature of Medical Staff Sponsor: _____

Date: _____



Boulder Community Health

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA),
PRIVACY AND SECURITY ACKNOWLEDGMENT

The Federal Health Insurance Portability and Accountability Act (HIPAA) provides patient protections in connection with the use and disclosure of their health information, in addition to those protections that

exist under Colorado State Law. Boulder Community Health (BCH) is committed to protecting the As an individual affiliated with BCH, you are expected to comply with the Notice of Privacy Practices adopted by BCH, as well as BCH privacy and security policies and procedures, including the following:

- Individuals must treat all information that may relate to patients of BCH as confidential and privileged.
Individuals must restrict their access of PHI to only the minimum extent necessary to complete their assigned job/duties, including their own record
Individuals must not discuss PHI in a public area or with individuals that do not have a need to know the information.
Individuals must secure PHI to avoid inadvertent disclosure including electronic and paper.
Upon separation with BCH, individuals will continue to maintain the confidentiality and privacy of information that may have been acquired.
Individuals actions must not lead to an unauthorized disclosure of PHI (e.g. improperly downloading, introducing malware to the organization, responding to phishing emails, sharing usernames and passwords, etc.)
Individuals must promptly report any activity that is believed to violate HIPAA or BCH's privacy and security policies to departmental leadership and/or the Privacy Officer, Security Officer, or Compliance Hotline.

I, _____ agree to comply with the terms set forth above. I acknowledge my understanding of my duties and responsibilities as set forth herein, and have been given an opportunity to ask questions about these responsibilities. I understand that my failure to comply with these terms during my affiliation with BCH may result in corrective action, termination of contract, and may result in civil and/or criminal liability and penalties.

Signature

Date

Title/Role

Organization/Company

BCH Department Leadership/Sponsoring Individual Signature