Boulder Community Health

Boulder Community Health Student Application

Thank you for your interest in a student rotation at Boulder Community Health.

It is the student/school's responsibility to arrange their preceptor. You may use the following link to locate providers at BCH: https://www.bch.org/find-a-physician/

All documentation required is listed on page two of the application. All documentation must be turned in the medical staff department **AT LEAST** seven business days before the start of the rotation. Submitting your application later may result in having your rotation bumped.

Students must wear school badge for identification.

Students will be granted EPIC read-only access for rotations of 21 days or longer. Rotations shorter than 21 days will not be eligible for EPIC access.

Once all paperwork is submitted and approved, students will receive an approval letter sent to the email listed on their application. **You cannot start your rotation if you have not received your approval letter.** Please reach out to the medical staff department if you do not receive an approval letter.

Student Signature: _____

Boulder Community Health

MEDICAL STAFF-SPONSORED STUDENT APPLICATION

Phone 303-415-7490 ● Fax 303-415-7498 ● Email medstaff_mail@bch.org

Complete Name of Applicant: _____

Last Four of SSN: _____ Date of Birth: _____

Complete Address: _____

Phone:_____E-Mail: _____

Name of School: _____
(Medical, Technical Training)

Field of Study: _____

Name of Sponsoring Medical Staff Member: _____

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

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

1. Signed Application – Signed by both the student and sponsoring practitioner(s). **It is the responsibility of the student to get their application signed by their sponsor.**
2. Letter of good standing - from training program
3. HIPAA Form – Page 5 of this application.
4. Workers Compensation.
5. Professional Liability Insurance – with limits of liability of at least $1m/$3m.
6. Drug screen - recent 10 panel.
7. Comprehensive criminal background check.
8. IT Access form - page 6 of application. Only for those with a rotation longer than 21 days.
9. Health Requirements as required in the student agreement:

   a. Rubella–Titer of 1:10 (or immune) per laboratory finding, or two vaccines on or after 12 months

   b. Measles/Rubeola–Positive rubeola titer or two doses of live vaccine given after the age of 15months 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. HepatitisB–Three vaccines or serologic proof of immunity

   e. Influenza–vaccination during influenza season (November-March).

Boulder Community Health

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 statue 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)

_____Check here if student already has EHR Access at BCH.

Boulder Community Health

Delineation of Procedures

Name of Applicant:_____ Field of study: _____

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

Medical:		**Surgical:** **REQUIRED: You must complete an orientation with the surgery educator before entering the OR.**	
☐	History/Physical examination (May not become part of the permanent legal patient record or dictated on the hospital system)	☐	Assist with patient positioning/draping
☐	Patient education	☐	Assist with clipping and marking
☐	Assist with patient plan of care	☐	Pass surgical instruments from mayo
☐	Assist with patient discharge planning	☐	Handle suction and/or sponge surgical field
☐	Rounds	☐	Retract
☐	Assist with skin testing, including performance and reading	☐	Assist surgeon in utilizing special equipment
☐	Assist with taking of cultures	☐	Break down surgical field, deliver instruments for reprocessing
☐	Assist with urinary/Bladder catheterization	☐	Assist with anterior nasal packing for epistaxis
☐	Assist with nasogastric intubation	☐	Assist with excision fulguration of simple skin lesion
☐	Assist with gastric Lavage	☐	Assist with I & D of superficial skin infection
☐	Injections	☐	Assess, dress & bandage superficial wounds
☐	Venipuncture	☐	Assist with debridement
☐	Arterial puncture (blood Gases)	☐	Assist with suture/removal of sutures
☐	Assist with flex/sig	☐	Assist with removal of foreign body from exterior surface
		☐	Assist with removal of impacted cerumen
Obstetrical **(Limited to Medical and CNM students)**		☐	Assist with insertion/removal of drains
☐	Assist with assessment of pregnant women	☐	Assist with dressing changes
☐	Assist with assessment of fetal/neonate well being	☐	Assist with Application of traction
☐	Assist with sterile vaginal exam	☐	Assist with sprains including strapping and splinting
☐	Assist with diagnostic vaginal testing	☐	Assist with casting, including application and removal
☐	Assist with ultrasound	☐	Assist with urinary and bladder catheterization
☐	Assist with use of internal scalp electrodes	☐	Manage MAC, general and regional anesthetics; including but not limited to airway management as well as invasive and non-invasive monitoring
☐	Assist with intrauterine pressure catheters		
☐	Assist with normal spontaneous vaginal delivery of baby and placenta		
☐	Assist with assessment and repair of first and second degree vaginal and perineal lacerations		
☐	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:_____

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 privacy and security of our patients' health information.

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**

As an employee, volunteer, contractor, or medical staff member of Boulder Community Hospital (BCH) or any subsidiary or affiliate thereof, I understand that access to certain information is required for me to perform my duties. Some of this information may concern patients being treated at BCH or it may concern the operations of BCH.

I understand that any patient medical information belongs to the patient. I am only permitted to access patient medical information (whether maintained electronically, on paper, or otherwise), to the extent that it is necessary to provide patient care and perform my duties and in accordance with applicable laws. I also understand that all medical and personal information regarding patients is confidential by law and may not be revealed or discussed with other patients, friends or relatives, or anyone else within or outside of BCH except as authorized by BCH or required by law.

I also understand that other information regarding the operations of BCH and their partners, whether maintained electronically, on paper, or otherwise is considered confidential. This information may concern, for example, employees, financial operations, strategic or business plans, quality assurance, utilization review, risk management, research, contracting, procurement, computer code, and credentialing of staff. I understand that I am only authorized to access this information if it is required for me to perform my duties. This information should not be discussed with others within or outside BCH except to the extent that this discussion is necessary to perform my duties.

I understand that I am required to protect BCH patient or operations information from loss, misuse, unauthorized access, or unauthorized modification. I also understand that my use of the system may be monitored. I understand that I may be given a user ID and password to the BCH network and/or computer system(s). I will safeguard the user ID and password given to me. I acknowledge that I am strictly prohibited from disclosing my user ID and password to anyone, including my family, friends, fellow workers, supervisors, and subordinates, for any reason. I agree to contact the Information Technology Service Desk immediately if I suspect that my password is known and/or being used by another person.

I understand that I may only use my User ID and password to perform my duties. I agree that I will not use anyone else's User ID and password to obtain access to any BCH computer system(s). I understand that I will be held accountable for all work performed, changes made to the system or databases, or information accessed under my User ID and password and that I am not to allow anyone else to access the BCH network/computer system using my User ID and password.

I understand that I should not store sensitive data on laptops or other portable devices. Mobile and portable systems and/or devices (including but not limited to laptops, notebook computers, PDAs, handheld devices, wireless telephones and removable storage media devices) will be stored securely when not in use and that I will immediately report lost, stolen or missing portable systems/devices to the BCH IT Service Desk by calling 303-415-5100.

I understand that failure to follow this policy regarding the confidentiality of information is cause for: termination of employment; termination of an independent contractor relationship; revocation of medical staff membership and privileges; revocation of access to all BCH network/computer systems; and possible legal action by any patient or other person injured by my breach of this policy.

My signature below indicates my understanding of the aforementioned mandates regarding the use of any User ID and password I am assigned pursuant to my responsibilities with BCH. In addition, users with access to the BCH electronic systems must comply with the BCH HIPAA Privacy and Security policies which are available upon request.

Printed Name: _____	Signature: _____
Last Four Digits of SSN: _____	Date: _____