CoxHealth

CoxHealth Student Learning Experience Application

Application materials are due at least **30 days** prior to the scheduled start of your rotation. Submit all documents to student_education@coxhealth.com or fax to 417-269-8472.

Personal Information		
Legal First Name:	Middle Initial:	Last Name:
Preferred Full Name:		
Preferred Email Address:		
School Email Address:		
Address:		
City:	State:	Zip:
Phone Number:	Are you a CoxHealth Employee?:	
Requesting Charting Access?:	Cerner Student Login (if applicable):	
Last 4 digits of Social Security #:	School Student ID #:	
Vehicle Make and Model:	License Plate Number:	

Emergency Contact Information	
Name:	Relationship:
Phone Number:	

Program Information		
Name of School:		
Program Contact:	Phone Number:	
Contact Email:		
City:	State:	Zip:
Program of Study (FNP, MD, DO, PA, etc.):		
Date of Entry:	Anticipated Graduation Date:	
Start Date of Rotation (mm/dd/yy):	End Date of Rotation (mm/dd/yy):	

Required Documentation and Orientation Materials

Please include the following documents with the clinical rotation application.

- ☐ Student Learning Experience Engagement Form signed by provider/CoxHealth supervisor and student

- ☐ A letter from the student's school which confirms enrollment
- ☐ Professional Photo
- ☐ Documentation of adequate professional's liability malpractice insurance
- ☐ Documentation of items on Compliance Checklist

Orientation Materials

- ☐ Blood/Body Exposure Policy Agreement Form
- ☐ Confidentiality Agreement
- ☐ HIPAA Exam
- ☐ Student Orientation Exam

Submit all documents to student_education@coxhealth.com or fax to 417-269-8472.

Prerogatives of Student

Students may participate with procedures which pose no risk to the patient provided the supervising clinician is directly present, the patient is aware of the student's professional status, and patient consents.

Effect of Application

In making application as a clinical student to CoxHealth:

I hereby release from liability all those who, review, act on or provided information regarding my competence, professional ethics, character, health status, and other qualifications for staff appointment and clinical privileges. I further attest to the correctness and completeness of all information furnished.

I hereby understand that nothing herein shall be construed as creating an Employee/Employer relationship between myself and CoxHealth. I will hold CoxHealth harmless for any injuries to me as a result of being on the CoxHealth premises for my own benefit.

Disability Acknowledgement

I am able to meet the essential functions of the clinical practicum for which I am applying, with or without reasonable accommodation. Students who are seeking accommodation are highly encouraged to notify their school and CoxHealth at least thirty (30) calendar days prior to the Student's start date of the clinical practicum at CoxHealth. While CoxHealth will attempt to review late requests for accommodation, the delay may result in accommodations not being available at the start of the Student's clinical practicum.

Please initial in the appropriate space: ______________ Yes ______________ No

CoxHealth Recruitment

I would like to be contacted by CoxHealth Recruitment.

Please initial in the appropriate space: ______________ Yes ______________ No

Student Name (Printed) Student Signature Date

TB Risk Assessment Questionnaire [1]

Name: ________________________________

School: _____________________________ **Program Type** (NP/MD/EMS etc.): ________________________

Date of Risk Assessment (date you are completing this form): __________________________

History of positive TB test or TB disease: Yes☐ No☐

*If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.**

If no, continue with questions below.

If there is a "Yes" response to any of the questions below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

RISK FACTORS	Yes	No
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB[2]		
2. Close contact with someone with infectious TB disease since the last TB test		
3. Birth in high TB-prevalence country** (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)		
4. Travel to high TB-prevalence country** for more than 1 month (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)		
5. Current or former residence or work in a correctional facility, long-term care facility, or homeless shelter		
6. Current or planned immunosuppression including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g. infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication		

*Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infections TB, the TB risk assessment is no longer required.

By signing below, I attest that all information completed on this form is true.

Signature: ____

[1] California Department of Public Health, California Tuberculosis Controllers Association, and the Centers for Disease Control and Prevention (CDC).

[2] Centers for Disease Control and Prevention (CDC). Latent Tuberculosis Infection: A Guide for Primary Health Care Providers. 2013. (https://www.cdc.gov/tb/publications/LTBI/default.htm)

CoxHealth

Springfield, MO

CONFIDENTIALITY & SECURITY AGREEMENT

(**Workforce Member)**

means employees, volunteers, medical staff and other persons whose conduct, in the performance of work for CoxHealth, is under the direct control of CoxHealth, whether or not they are paid by CoxHealth. This includes full and part-time employees, affiliates, associates, students, volunteers, and staff from third-party entities who provide services to CoxHealth.

CoxHealth collects and maintains personal health information or PHI about our patients. Federal and State regulations on patient privacy and confidentiality limit how health care providers and their workforce members may use and disclose this information. As a workforce member of CoxHealth and its Affiliated Entities, I understand that I may come in contact with medical and business related information, through written or computerized records, computer programs and applications, reports, documents, ledgers, written correspondence and verbal conversations in meetings or around hospital staff. All information that I become aware of is considered CONFIDENTIAL and is not to be shared with anyone other than those authorized. Confidential information, verbal or written, is owned by CoxHealth (including Email) as indicated in this Security Agreement only for work/study related issues. I also understand that I am obligated to maintain the confidentiality of all Patient Safety Work Products (PSWP) such as incident reports, peer review, medical and other sensitive or private information as stated in the Patient Safety and Quality Improvement Act of 2005.

By signing this document, I am agreeing to follow all of the confidentiality and security policies of CoxHealth. I realize that failure to follow these policies may be a violation of state and federal laws governing patient confidentiality and will result in disciplinary action up to and including termination of my employment, educational opportunities or workforce member status and termination of my access to CoxHealth's electronic medical record.

1) I will treat all patient and/or business information that I see, hear, or receive, as confidential and privileged information and I will not access employee personnel information without going through the appropriate channels.
2) I will follow all of the confidentiality and security policies of CoxHealth.
3) I will NOT use CoxHealth's electronic medical records to access medical records of my family, friends, or co-workers. I realize that inappropriate access of medical records will result in disciplinary action up to and including termination of employment/educational opportunities. Workforce members who were given access to the CoxHealth computer systems will have their access immediately terminated.
4) I understand that should I need access to medical information on my family members that I will follow the same process as any other person by filling out an authorization and obtaining copies from the Health Information Management Department.
5) I agree that I will only access and review medical records of CoxHealth for purposes of my employment, educational opportunity or workforce status at CoxHealth.
6) I understand that federal law requires all uses of patient information, including for treatment, be limited to that which is reasonably necessary to accomplish the purpose for which information is being used.
7) I will NOT use the patient information of CoxHealth for research purposes, without prior approval or the patient's written authorization.
8) If I do use CoxHealth's patient information for research, I will enter the disclosures in the CoxHealth HIPAA Accounting of Disclosures database. I realize that failure to document these disclosures is a violation of federal law and will result in disciplinary action.
9) I understand that I may not disclose patient information to any person or entity other than as necessary to perform my job/educational tasks, and as permitted under CoxHealth's policies and procedures.
10) I understand that any patient or family requests for copies of medical records are to be referred to the Health Information Management Department. No approvals will be granted unless the release is consistent with applicable state and federal law.
11) I understand that CoxHealth's medical records are the property of CoxHealth and I may NOT retain or remove any patient information either in paper or electronic form without the written authorization of the Corporate HIPAA Privacy & Security Officer.
12) Medical records of CoxHealth may not be accessed or reviewed for any purpose not specifically stated in this policy unless CoxHealth receives a signed patient authorization form which authorizes CoxHealth to disclose that patient's medical record to you or unless CoxHealth has provided such records to you for a specific purpose related to the health care operations of CoxHealth.
13) Federal law allows patients to request restrictions on how their medical records may be used and disclosed. I understand that it is my responsibility to adhere to any restrictions that have been placed on a patient's medical records.
14) I understand that I am personally responsible for my sign-on name and password. I understand that my sign-on is the equivalent of my signature and I am responsible for all work done under my sign-on.
15) I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost.
16) I will log off of any computer or applications as soon as I have finished using the computer application.
17) I will NOT allow others to use my personal sign-on and password. Nor will I attempt to learn another user's sign-on and password.
18) I understand that I am not permitted to use another person's sign-on and password to complete work under their name. Example: electronically signing another person's documentation.
19) I understand that using another person's sign-on and password to access medical information could be considered as accessing data under false pretenses. This can be cause for termination of employment or workforce status and could result in criminal and civil penalties.
20) I understand and agree that I will ensure all email with PHI and sensitive information sent to external email addresses will be sent using Secure Email. Rights to the Secure Email program are granted by my supervisor.
21) If I believe that my sign-on and/or password has been compromised, I will immediately contact the CoxHealth Helpdesk at 269-3153.
22) I understand that a physician does NOT have the authority to authorize any changes to this policy, and cannot authorize me to access patient information that is not directly related to my job or educational opportunities.
23) I understand & agree to the guidelines & responsibilities related to the use of a cellular phone or mobile device for business use as stated in CoxHealth policy.

I have read the information Confidentiality Statement and the Security Agreement. I understand and acknowledge that in the event I breach any provision of this agreement, I will be subject to disciplinary action up to and including termination of employment, educational opportunity and/or workforce member status as well as reporting to any applicable licensing authorities. I also understand that failure to comply with the federal HIPAA regulations could result in civil and/or criminal penalties.

Name: ____

(Please print)

Signature:____ Date: __________________

COXHEALTH

SYSTEM POLICY – Employee Health (EH)

TITLE: Blood/Body Fluid Exposure and Follow-up
SUBMITTED BY: Carol Grantham
APPROVED BY: Nana Gaisie, M.D, Medical Director, Employee Health

PURPOSE:
To provide the procedure for management of Healthcare Personnel, Students, Volunteers, Patients and Visitors exposed to blood and body fluids.

POLICY:
Exposure to blood and other potentially infectious body fluids shall be evaluated with appropriate treatment provided, according to CDC guidelines. The policy is applicable to **Healthcare Personnel, Students, Volunteers, Patients, and Visitors** at CoxHealth who may incur a blood or body fluid exposure during the course of work, educational experience or as a Patient or Visitor, regardless of whether the exposure occurs in the clinical setting or otherwise.

SCOPE: All CoxHealth locations

DEFINITIONS:

1. Blood/Body Fluid Exposure:
   - Percutaneous injury in which blood or blood-derived fluids are transferred through the skin via a needle or other sharp object that has been contaminated with blood or blood derived fluids.
   - A mucous membrane exposure in which blood or blood-derived body fluids contact the mucous membranes of the eye, nose, and/or mouth.
   - Blood or blood-derived body fluid contact with non-intact skin, i.e. skin that is abraded, chapped, lacerated, or afflicted with dermatitis.
   - Ingestion of human breast milk by a neonate from a source other than the infant's mother.
   - Human bite injuries in which the skin is broken and blood exposure occurs to the mouth of the biter. Exposure may also occur to the bitten person if the biter has blood in their mouth prior to biting, or an open sore of the gums or mucous membranes such as active gingivitis, tooth abscess, or aphthous ulcer.

2. Body Fluids:
   - Blood.
   - Blood-derived body fluids, i.e. semen, cerebrospinal fluid, pleural fluid, peritoneal fluid, vaginal secretions, synovial fluid, pericardial fluid, amniotic fluid, or breast milk.
   - Any body fluid or substance containing visible blood.

- Un-fixed tissue or organ.
- Fluids or un-fixed tissues containing HIV, or lab specimens of fluid or un-fixed tissue containing HIV.

3. Healthcare Personnel - All persons who provide services at CoxHealth, whether paid or unpaid.

4. Students: All students who engage in educational experiences at Cox College and/or CoxHealth.

PROCEDURE:

A. In the event of a blood or body fluid exposure, the exposed person shall:
   1. Wash the site with soap and water or flush mucous membranes with water.
   2. Report **immediately** to:
      - Employee Health Nurse.
      - Nursing Administration Supervisor (NAO) in the event Employee. Health Nurse is unavailable.
      - Supervisor.
      - Appropriate Faculty Supervisor.
   3. Fax completed " **Blood and Body Fluid Exposure Form" (See Appendix A)** to:
      - Employee Health, Springfield **417-269-4996**
   4. Enter an incident report in the on-line reporting system. See Appendix B

B. Employee Health, Nursing Administration Supervisor, Appropriate Faculty Supervisor, or or Designated Persons will implement the following steps:
   1. For a **Known Source Patient,** order the following labs on source patient.
      a. "**Needle Stick Protocol"** as soon as possible on source patient.
      Ordering Physician "Employee Health"
      1) Needle stick protocol:
         - HIV 1 Antibody Screen
         - HIV Antigen Antibody by EIA
         - Hepatitis B Surface Antigen by EIA
         - Hepatitis C Antibody

   2. For **positive HIV** results on **Source Patient**, order **PEP baseline labs on exposed health care worker**
      - Hepatitis B Surgace Antibody
      - Hepatitis B Surface Antigen
      - Hepatitis C Antibody
      - HIV Antigen Antibody by EIA
      - ALT/AST
      - CBC
      - CMP
      - Beta-hCG serum (if female)

3. For **positive Hepatitis B Surface Antigen results** on **Source Patient**, order **baseline Hepatitis B labs on exposed health care worker**.
    a. Hepatitis B Surface Antibody
    b. Hepatitis B Surface Antigen

4. **For positive Hepatitis C result on Source Patient order Hepatitis C baseline labs on exposed person.**
    - ALT/AST
    - Hepatitis C Antibody

C. For an **Unknown Source Patient** order following baseline labs on exposed person.
   1. HIV Antigen Antibody by EIA
   2. Hepatitis C Antibody
   3. Hepatitis B Antibody
   4. Hepatitis B Antigen

D. Counsel exposed person utilizing attached document. **(See Appendix C).** For any questions, individuals may contact Employee Health.

E. **Coordinate Post Exposure Prophylaxis (PEP) evaluation with: (See Appendix D).**
   1. Occupation Medicine during regular office hours.
   2. Emergency Department when Occupational Medicine office is closed.
      - **If source patient is positive for HIV infection.**
      - **If source patient is positive for Hepatitis B infection and exposed person is non immune to Hepatitis B**
      - **Unknown Source**

F. Follow-up appointments for employees and volunteers will be completed by Employee Health.

REFERENCES:

http://wwwnc.cdc.gov/travel/yellowbook/2014/chapter-2-the-pre-travel-consultation/occupational-exposure-to-hiv

http://www.nccc.ucsf.edu/about nccc/pepline/

APPENDIX A **Blood Body Fluid Exposure form (see content linkage)**
APPENDIX B **<u>Incident Report</u>**
APPENDIX C **What You Should Know If You Have Been Exposed to HIV.docx (see content linkage)**
APPENDIX D **Determining HIV Post-Exposure PEP.docx (see content linkage)**

CoxHealth System Policy: Blood/Body Fluid Exposure & Follow-Up
Student/Faculty Acknowledgment and Agreement to Comply

I/My Child and I have reviewed and understand the Blood/Body Fluid Exposure and Follow-Up CoxHealth System Policy ("Policy"). I/My Child and I understand and agree to comply with the Policy, including any revisions made at CoxHealth's sole discretion, in the event of a blood/body fluid exposure during My/My child's educational experience (regardless of whether such exposure occurs during clinical or non-clinical activities) at CoxHealth, or at one of CoxHealth's related facilities or entities. I/My Child and I agree that in the event of a blood/body fluid exposure, My/My Child's labs will be drawn in compliance with the Policy. I/My child and I understand and agree that My/My Child's failure to comply with the Policy shall be grounds for My/My Child's immediate dismissal from My/My Child's educational experience at CoxHealth or at any of its related facilities or entities.

Student/Faculty:

____

Print name Signature Date

Parent/Guardian (required in addition to the student's signature above, if the student is under age 18):

____

Print name Signature Date