Memorial University Medical Center (Savannah, GA)

- Applied Learning Experience Agreement
- Authorization for Release of Confidential Records and Information
- Confirmation of Receipt of Ethics and Compliance Training Materials
- Acknowledgement of Diversity, Universal Precautions, and Emergency Codes Training
- Required PSI Background Check and Drug Screen ($76.00)
MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER, INC.
STUDENT APPLIED LEARNING EXPERIENCE AGREEMENT

In consideration for participating in an applied learning experience (hereinafter referred to as the "A.L.E.") at Memorial Health University Medical Center, Inc. (hereinafter referred to as the "Facility") where I may participate in such an A.L.E., I hereby agree to the following:

1. To follow the administrative policies, standards and practices of the Facility when in the Facility.
2. The Facility will retain responsibility for the care of its clients and patients.
3. The Facility will supervise practice of all students insofar as their presence and A.L.E. assignments affect the operation of the Facility and its care, direct and indirect, of its clients and patients.
4. To report to the Facility on time and to follow all established regulations of the Facility.
5. To keep in confidence all medical, health, financial and social information (including mental health) pertaining to particular clients or patients.
6. To use and disclose "protected health information" of patients as defined in 45 C.F.R. § 164.501 that I receive from Facility, or that I create or receive on behalf of Facility (collectively, the "Information") only to the extent necessary (i) to perform my specific obligations under this Agreement, and (ii) for my own management and administration and to carry out my legal responsibilities in compliance with 45 C.F.R. § 164.504(e)(2)(i)(A) and (e)(4). Notwithstanding anything to the contrary herein, this Agreement shall not be deemed to authorize me to use or disclose Information in a manner that would violate HIPAA Privacy Rules, 45 C.F.R. § 164.501 et seq., if done by a HIPAA covered entity.
7. The services provided hereunder shall be in conformance with the Facility policies and procedures established from time to time by the Facility, applicable standards of The Joint Commission and federal, state and local laws and regulations governing the provision of professional medical services. Periodic medical review shall be conducted to insure compliance with the foregoing in quality assurance and medical audit programs of the Facility and its staff.
8. To not publish any material related to my A.L.E. that identifies or uses the name of the, the Facility or its members, clients, students, faculty or staff, directly or indirectly, unless I have received written permission from the Institution and the Facility.
9. To comply with all federal, state and local laws regarding the use, possession, manufacture or distribution of alcohol and controlled substances.
11. To arrange for and be solely responsible for my living accommodations while at the Facility.
12. To provide the necessary and appropriate uniforms and supplies required where not provided by the Facility.
13. To wear a nametag that clearly identifies me as a student.
14. To complete any and all relevant patient care training provided by Facility, including but not limited to Cultural Diversity Training and Ethics Training.

Further, I understand and agree, unless otherwise agreed to in writing, that I will not receive any monetary compensation from the Institution or the Facility for any
services I provide to the Facility or its clients, students, faculty or staff as a part of my A.L.E.

Unless otherwise agreed upon in writing, I also understand and agree that I shall not be deemed to be employed by or an agent or a servant of the Institution or the Facility; that the Institution and Facility assume no responsibilities as to me as may be imposed upon an employer under any law, regulation or ordinance; that I am not entitled to any benefits available to employees; and, therefore, I agree not to in any way to hold myself out as an employee of the Institution or the Facility.

I understand and agree that I may be immediately withdrawn from the A.L.E. based upon a lack of competency on my part, my failure to comply with the rules and policies of the Institution or Facility, if I pose a direct threat to the health or safety of others or, for any other reason the Institution or the Facility reasonably believes that it is not in the best interest of the Institution, the Facility or the Facility's patients or clients for me to continue. Such party shall provide the other party and myself with immediate notice of the withdrawal and written reasons for the withdrawal.

I understand and agree to show proof of professional liability insurance in amounts ($1,000,000 per occurrence and $3,000,000 annual aggregate) satisfactory to the Facility and the Institution, and covering my activities at the Facility, and to provide evidence of such insurance upon request of the Facility.

I further understand that all medical or health care (emergency or otherwise) that I receive at the Facility will be my sole responsibility and expense.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this Applied Learning Agreement; and that I, or my parent and/or guardian, have read carefully and understand the above “Applied Learning Experience Agreement”; and that I have freely and voluntarily signed this “Applied Learning Experience Agreement”.

____________________________________________________________________
Student Signature          Date

____________________________________________________________________
Educational Institution                                                     Program of Study

____________________________________________________________________
Witness Signature          Date

Name:________________________________
(Please print)
Address:______________________________

Revised: 6/22/10
MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER, INC.
STUDENT AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL RECORDS AND INFORMATION

To: ____________________________ (hereinafter referred to as the "Institution"), and
Memorial Health University Medical Center, Inc. (hereinafter referred to as the
"Facility") where I participate in or request to participate in an applied learning
experience.

RE: ________________________________________________________________
Print Student Name

As a condition of my participation in an applied learning experience and
with respect thereto, I grant my permission and authorize the Institution to release my
educational records and information in its possession, as deemed appropriate and
necessary by the Institution, including but not limited to academic records and health
information to the Facility where I participate in or request to participate in an applied
learning experience. I further authorize the release of any information relative to my
health to the Facility for purposes of verifying the information provided by me and
determining my ability to perform my assignments in the applied learning experience. I
also grant my permission to and authorize the Facility to release the above information
to the Institution. The purpose of this release and disclosure is to allow the Facility and
the Institution to exchange information about my medical history and about my
performance in an applied learning experience.

I further understand that I may revoke this authorization at any time by providing
written notice to the above stated person(s)/entities, except to the extent of any action(s)
that has already been taken in accordance with this "Authorization for Release of
Confidential Records and Information".

I further agree that this authorization will be valid throughout my participation in
the applied learning experience. I further request that you do not disclose any
information to any other person or entity without prior written authority from me to do so,
unless disclosure is authorized or required by law. I understand that this authorization
shall continue in force until revoked by me by providing written notice to the Institution
and the Facility, except to the extent of any action(s) that has already been-taken in
accordance with this "Authorization for Release of Confidential Records and
Information".

In order to protect my privacy rights and interests, other than those specifically
released above, I may elect to not have a witness to my signature below. However, if
there is no witness to my signature below, I hereby waive and forfeit any right I might
have to contest this release on the basis that there is no witness to my signature below.
Further, a copy or facsimile of this "Authorization for Release of Confidential Records and Information" may be accepted in lieu of the original.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this "Authorization for Release of Confidential Records and Information"; and that I, or my parent and/or guardian, have read carefully and understand the above "Authorization for Release of Confidential Records and Information"; and that I have freely and voluntarily signed this "Authorization for Release of Confidential Records and Information".

______________________________  ____________________
Student Signature               Date

______________________________
Parent/ Guardian Signature
STUDENT ACKNOWLEDGEMENT OF
DIVERSITY, UNIVERSAL PRECAUTIONS AND
EMERGENCY CODES TRAINING

I hereby certify that I have received the Memorial Health Student Affiliations Orientation Booklet and that I have read and understand the regulations outlined.

I hereby certify that I have read and understood the following documents attached to this Orientation booklet:

- Diversity and Cultural Competency packet
- Universal Precautions and Infection Control packet
- Emergency Codes information

I acknowledge that I have had the opportunity to ask any questions about these materials.

Student Signature:

Student Printed Name:

School Name:

Program:

Date Signed:

Revised 6/22/10
STUDENT ATTESTATION OF RECEIPT OF ETHICS AND COMPLIANCE TRAINING MATERIALS

I hereby certify that I have received the following documents:

- Ethics and Patients' Rights Required Training

I understand that I have an obligation to acknowledge any known or suspected violations of Memorial's Code of Business Practice or policies.

I have received a copy of Memorial's Code of Business Practice.

I am aware of the process to report any concerns I may have regarding Memorial's business practices—I may inform my supervisor, management, contact the Ethics line for anonymous reporting or contact the Ethics Office directly.

I am aware that I can report any concern to Memorial management, the ethics and compliance office or a government regulatory body without fear of retaliation.

I understand the rules and regulations that protect our patient's rights to privacy of their medical information.

I understand the importance of the laws and regulations that govern how we can and can not compensate physicians.

I understand that all arrangements with physicians must be carefully reviewed in strict accordance with Memorial's policy prior to making any agreements with a physician.

I understand the necessity of accurate documentation and coding practices.
I acknowledge that I have had the opportunity to ask any questions about these materials.

Student Signature:

Student Printed Name:

School Name:

Program:

Date Signed:

Revised 6/22/10
HOW TO COMPLETE YOUR BACKGROUND CHECK AND DRUG SCREEN

Memorial Health contracts with Professional Screening & Information, Inc. (PSI), to provide background checks and a drug screen at a reduced rate of $76.

Background Check: If you have not had a background check within six months of your Memorial rotation, you need to complete a background check using PSI.

Drug Screen: If you have not had a 10-panel drug screen within 45 days of starting your rotation at Memorial, you are required to complete a drug screen through PSI.

To initiate a background investigation and/or a drug screen through PSI, follow the steps below. If you have any questions, please contact PSI directly. A copy of your background check and drug screen will be sent directly to Memorial by PSI.

STEP 1:
Login as an existing user or create an account.

- Go to www.psibackgroundcheck.com.
- Click the "Individuals/Organizations LOGIN" button in the upper right-hand corner of the screen. New users should create an account and then enter required personal information.
- Click the "Individuals" button. New users should create an account and then enter required personal information.
- Returning users should login using the information used when their account was established.
- If you forget your password, select the "Forgot Password" button and after answering your security questions, your password will be emailed to the address on record.
STEP 2:
Select background type and complete required information.

- After creating an account or to initiate another background investigation, select the “Background Type” tab (if not already displayed).
- Select the “Applicant” type. Memorial students should not choose the “Individual” type.
- Enter the package code for the background composition the school has selected, which is PP1. (If you are only completing a drug screen, enter the package code PP2).
- Enter the school’s organization code, which is CUST_178.
- Select the location or campus you’re attending.
- Select the program for which the background investigation is requested. After completing the background type, complete all required information.
- All fields MUST be completed.
- Save each set of responses for an entry prior to selecting done.
- There are suggested requirements for the amount of information to be supplied (i.e. years of residency history), be as complete as possible when answering these questions.

STEP 3:
Acknowledgment and payment.

- After completing all required information, read the acknowledgment page, check the appropriate boxes, and enter the date for your electronic signature.
- The cost for the background check and drug screen $76. The program accepts MasterCard and Visa or money orders. Please follow the instructions on the “Check Out” page and you will receive a confirmation that your payment has been accepted.

STEP 4
Drug testing.

- After completing your background request, you will receive an email with instructions for completing your drug test. It will tell you where to go for your drug test and what to do to obtain your drug test.
- Your drug screen results will then be reported along with your background investigation results.

After PSI receives your payment, the background investigation will be completed within three to five days. During this period, feel free to login and check the status of your background investigation. Once complete, each user has 14 days to download and/or print a copy. Additionally, maintaining continuous enrollment at this school provides each user the ability to change an unlimited number of times the client/clinical site where they can view a background investigation. This can be done from the “Your Background Check Information” screen, when returning users login.

Questions or comments?
Call PSI at 706-235-7574
Professional Screening & Information, Inc.
P.O. Box 644
Rome, GA 30162
www.psibackgroundcheck.com

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