The Hospitals of PROVIDENCE

**Instructions for Completing Required Documentation for Clinical Rotations**

Welcome to The Hospitals of Providence. An active Affiliation Agreement is required in order to complete any clinical rotations in the network. In an effort to ensure we provide a positive learning experience and ensure the safety of our patients, employees, & students, the following are required, in their entirety, to be submitted a minimum of two weeks from the clinical start date:

- Faculty/Instructor Credentialing form of individual overseeing the students
- Course Syllabus/Objectives
- Skills Checklist
- Clinical Site Request Form
- Pre-Clinical Clearance form to include the Faculty/Instructor (Separate Link)
- Car License Plate form
- Request to access Clinical Applications (limited to last semester nursing students only). Contact facility to schedule training.
- Read the following information sheets: Student Orientation Sheet and Emergency Codes (each facility has a specific link). Print the page titled Orientation Checklist. Date and initial each box where appropriate, then print your name in the blank space provided and sign at the bottom. This is required for both students and Faculty/Instructor.

Complete required safety, privacy and security training by clicking on the HIPAA education video link below "HIPAA: Your Health Information, Your Rights" (watch all available videos). Once all videos have been watched, complete the attached attestation form.

https://www.youtube.com/watch?v=QWRn2r5R7ts&index=2&list=PLACD9536723837201

The forms that need to be completed prior to the first day of clinical for faculty/instructors, and students include: 1.) Facility-Specific Student Orientation Checklist (Confidentiality Statement & Statement of Responsibility this will need to be obtained from the contact person at the specific campuses), 2.) Information Privacy & Security & HIPAA Training Form and 3.) Orientation Checklist.

# Information Privacy & Security & HIPAA Training

**As a Covered Person under the Tenet Healthcare Corporation Quality, Compliance and Ethics Program Charter, I certify that I viewed and agree to abide by the requirements of the "Information Privacy & Security & HIPAA Training".**

**Name (please print): _____**

**Date of Session: _____**

**Signature: _____**

# FACULTY/INSTRUCTOR CREDENTIALING FORM

*This form is to be completed and submitted with the Pre-Clinical Clearance Form in compliance with The JC requirements every semester. Directions: Please print or type the requested information into the spaces provided.*

| | | |
|---|---|---|
| Faculty/Instructor's Name: | Home: | Cell: |
| Email address: | Office: | |
| ID Number: | | |
| Emergency Contact: | Contact Number: | |
| Credentials: | | |
| License #/State/Expiration Date: | Primary Source:<br>Verified: | CPR Status:<br>Verified: |
| Organization/School: | | |
| Title/Position: | | |
| Date of Employment: | | |
| Briefly describe the qualifications/experience(s) that qualify this person as being competent to serve as a clinical rotation instructor:<br><br>**(Attach Copy of the Pre-Clinical Clearance Form)** | | |
| I hereby verify that the above information is current and accurate: | | |
| Faculty/Instructor Signature: | Date: | |
| Immediate Supervisor's Signature: | Date: | |
| License & CPR status verified by: | Date: | Initials: |

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# Clinical Site Request Form

**Date Request Initiated:** _____

**Name of Requester:** _____

**Instructor(s) Name &** _____

**Contact Number:** _____

_____

**Name & Address of School:** _____

_____

_____

**Course Number/Title:** _____

**Description of Student(s):** _____

**Number of Student(s):** _____

**Department/Unit(s) desired for clinical experience:** _____

**Dates of clinical rotation:** **Days of the week:** _____

**Dates on the unit(s):** _____

_____

**Time students will be on the unit:** _____

**Affiliation Agreement is current?** ☐ **Yes** ☐ **No**

**Action being taken to:**

_____

**Comments:** _____

_____

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## Student Clinical Rotation Car License Plate Log

**Name of Nursing School:** _____

**Clinical Instructor:** _____

**Clinical Dates:** _____

**Clinical Shift:** _____

| Name (Print) | Car Model | Car Make | Year | Color | License Plate Number |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
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| 18. | | | | | |
| 19. | | | | | |
| 20. | | | | | |

**The Hospitals of Providence**
**Required Data for Student Access to Electronic Documentation**

| Name | Birth Month/Day | Student ID | Email Address | Phone Number |
|---|---|---|---|---|
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## Contact Information:

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