RIVERSIDE

# Application for Student Placement

*for Non-Riverside College Student Learners*

*RHS-EXT-Attachment 503.C*

***PLEASE PRINT***

**STUDENT INFORMATION:**

Name: _____ Last 4-digit SSN *(Required)* _____

Address: _____ Phone: _____

_____ Email: _____

_____ Date of Birth: _____

| | | | |
|---|---|---|---|
| Are you currently a Riverside Health System employee? | ☐ YES | ☐ NO | If you answered **YES** to any question, enter start and end date (month/year), and position held and location: |
| Have you ever worked for Riverside Health System? | ☐ YES | ☐ NO | |
| Are you eligible for rehire? | ☐ YES | ☐ NO | |

**SCHOOL (Sponsoring Organization):**

Name of School: Virginia Peninsula Com.Col. Coordinator: Jenni Jones

Address of School: 99 Thomas Nelson Drive Coordinator Phone: (757) 825-3867

Hampton, VA 23666 Coordinator Email: jonesje@vpcc.edu

_____ Emergency Contact: _____

Program / Practicum / Field of Study: ADN / nursing Emergency Contact Phone: _____

GPA: _____

**LOCATION OF LEARNING EXPERIENCE:**

| Riverside Facility: | Department: | Department/Preceptor: Name & Phone | Total Requested Hours: |
|---|---|---|---|
| | | | |

**Learning Experience** **Start Date:** _____ **End Date:** _____ **Anticipated Program Graduation Date:** _____

**REQUIREMENTS TO BE COMPLETED PRIOR TO LEARNING EXPERIENCE:**

1. *Students must provide their schools with valid documentation that all health and safety requirements that follow have been completed prior to submission of this application for placement. Riverside reserves the right to review such documentation on request.*
2. *This application is to be submitted to the Riverside Education Contracts Department 30 days prior to the requested learning experience start date.*

***ALL ILLEGIBLE AND/OR INCOMPLETE APPLICATIONS WILL BE PROPERLY DISPOSED OF TO ENSURE CONFIDENTIALITY.***

**STUDENT NAME (*Please Print*)** _____ **CURRENT YEAR** SP23

**SCHOOL** Virginia Peninsula Community College **PROGRAM** ADN

***PLEASE PLACE A CHECK IN THE BOXES BESIDE EACH REQUIREMENT BELOW INDICATING COMPLETION.***

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## HEALTH REQUIREMENTS

☑ Proof of up-to-date immunizations listed below has been provided to my school.

- Tetanus booster within past ten years (td or Tdap)
- Two measles, mumps & rubella (MMR) immunizations (or titers proving immunity)
- Hepatitis B (HBV)3-vaccine immunization series completed or in progress
  ***OR:*** Heplisav (HepB-CpG) 2-vaccine series – *This vaccine requires a positive titer (anti-HBs ≥10 mIU/ml) to prove immunity.*
- Two varicella (chickenpox) immunizations (or titers proving immunity)

☑ Proof of a Tuberculosis immunity has been provided to my school. Check method of proof of immunity:

☐ Negative IGRA test results from either (1) QuantifFERON®-TB Gold In-Tube test (GFT-GIT) or (2) T-SPOT®*B* test (T-Spot)

☐ Mantoux Tuberculin Skin Tests (TST) according to the protocols bulleted below.

- 2-TSTs within the past 12 months (initial placement only) of placement application.
- ***TST must not expire prior to the end of the learning experience.***
- For previous positive TST / IGRA, documentation of a negative chest x-ray subsequent to the positive TST. An updated TB Screening Questionnaire Documentation Form (RHS-EXT-503.H) must be submitted with each placement application.
- Following initial placement, students will be required to submit an updated TB Screening Questionnaire Documentation Form (RHS-EXT-503.H) with each placement application.

***NOTE: **A copy of current proof of immunity or current TST to be carried at all times while at a Riverside facility.***

☑ Annual Influenza vaccination has been completed and provided to my school. *Only intramuscular or intradermal vaccine will be accepted.*
Fall semester: *Completed by November 1st.* (Flu vaccine administered prior to August 1st will not meet this requirement.)
Spring semester: *Completed prior to the first day assigned to an RHS facility.*
Summer semester (May 1-August 30): *No influenza vaccination required.*

***NOTE: **A copy of the flu vaccination documentation to be carried at all times while at a Riverside facility (during fall and spring semesters).***

☑ Covid-19 vaccination with boost(s) as required.

***NOTE: **Original Covid-19 vaccination record to be carried at all times while at a Riverside facility.***

## URINE DRUG SCREEN & CRIMINAL HISTORY BACKGROUND CHECK REQUIREMENTS

☑ Proof of a negative 12-panel "Health Professional Panel" urine drug screen as defined by the laboratory of the school's choice.

☑ Proof of criminal history background check that included: *Virginia Statewide Criminal Records, Residency History & Social Security Alert, National Record Indicator (Criminal Records & Nationwide Sex Offender Registry), Nationwide Healthcare Fraud & Abuse Registry (FACIS Level III) databases, and Nationwide Federal Criminal Search.*

## CARDIOPULMONARY RESUSCITATION (CPR) REQUIREMENTS *(for nursing and allied health professionals)*

☑ Proof of current CPR certification by one of the two providers listed below has been provided to my school. Check type of certification:

☑ CPR for the Healthcare Provider-American Heart Association ***OR*** ☐ CPR for the Professional Rescuer-American Red Cross

- Only the above two CPR certifications are approved for placement at Riverside. (Other CPR certification, including online CPR certification, is not acceptable. A copy of the CPR card will not be accepted.)
- ***CPR certification must not expire prior to the end of the learning experience.***

***NOTE: **Original CPR card to be carried at all times while at a Riverside facility.***

## LICENSE / CERTIFICATION VERIFICATION *(for post-entry graduate or doctoral nursing students)*

☐ Proof of current professional credentials and educational requirements provided to my school.

*Type of license/certification* _____

*State / National* _____ *Expiration Date* _____

## MANDATORY SAFETY TRAINING

☑ Non-Riverside Safety Training Transcript attached

☑ Clinical students only: proper handwashing has been reviewed & demonstrated. *Documentation of skills checkoff will be required upon request*

***I certify that I have completed the requirements listed above. I understand that my TST and CPR must not expire during my learning experience at Riverside.***

**STUDENT SIGNATURE** _____ **DATE:** _____

**STUDENT NAME** (*Please Print*) _____ **CURRENT YEAR:** SP23

**SCHOOL:** Virginia Peninsula Community College **PROGRAM:** ADN

***I certify that:*** ☑ *I have verified the accuracy of the information listed above.* ☑ *Student background Report attached or attested.*
☑ *A Criminal History Background Check as required has been completed and no record of felony or barrier crimes exists.*

**SIGNATURE VERIFICATION BY SCHOOL OFFICIAL** _____ **DATE** 1/6/23

**PRINT NAME / TITLE OF SCHOOL OFFICIAL** Jenni Oakes Director of Allied Health

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## ANNUAL TUBERCULOSIS SURVEILLANCE SCREENING

*Tuberculosis surveillance is required by regulatory agencies for health care students / volunteers / interns.*

**PLEASE CHECK ALL SYMPTOMS THAT APPLY:**

- ☐ Persistent coughing
- ☐ Excessive fatigue
- ☐ Persistent fever
- ☐ Hoarseness
- ☐ Excessive swearing at night
- ☐ Coughing up blood
- ☐ Excessive weight loss
- ☐ ***I HAVE NO SYMPTOMS***

***I certify that the above information is correct.***

**STUDENT SIGNATURE** _____ **DATE:** _____

**STUDENT NAME** (*Please Print*) _____ **CURRENT YEAR:** _____

**SCHOOL:** Virginia Peninsula Community College **PROGRAM:** ADN

## ACKNOWLEDGEMENT FORM

***PLEASE INITIAL BESIDE EACH STATEMENT BELOW.***

In requesting placement at a Riverside Health System facility, I hereby acknowledge the following statements:

1. _____ *I understand that while in the capacity of student, I am not an employee, agent, partner of, or in joint venture with Riverside Healthcare Association, Inc. or its affiliates/subsidiaries (referred to herein as "Riverside Health System")*
2. _____ *I understand that I will not be covered by health insurance, Worker's Compensation Insurance, or life insurance provided by Riverside Health System.*
3. _____ *I understand that I must comply with the immunization requirements that are outlined in the Agreement between Riverside Health System and my sponsoring school.*
4. _____ *Riverside Health System is strongly committed to ensuring patient privacy as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) and other required patient privacy related laws and regulations. I may, during the course of my experience, become aware of confidential information concerning patients or employees. I understand that I am responsible for the safe keeping and non-disclosure of any information and agree not to use, disclose, or release any information concerning any employee or patient of Riverside Health System to any person without the expressed permission of Riverside Health System.*
5. _____ *I agree to abide by the rules, regulations, policies, and procedures of the Riverside Health System facility were assigned for my experience.*
6. _____ *I understand my continued participation in the educational experience is at the sole discretion of Riverside Health System. I understand that my learning experience may be terminated at any time should safety/privacy concerns or other violations of rules, regulations, policies, and procedures be identified. My sponsoring agency will be notified.*

***I certify that I have read and agree to abide by the terms of this Agreement and will comply with its requirements during and after termination of any educational relationship with RHS. I understand that violation of the provisions of this Agreement or other inappropriate acts involving RHS' information systems will subject me to consequences up to and including revocation of privileges, dismissal, and legal action.***

**SIGNATURE** _____ **DATE** _____

**STUDENT NAME** (*Please Print*) _____ **CURRENT YEAR** SP23

**SCHOOL** Virginia Peninsula Community College **PROGRAM** ADN

## RIVERSIDE HEALTH SYSTEM -- CONFIDENTIALITY AGREEMENT (Volunteers / Students / Interns)

1. **PROTECTION OF CONFIDENTIAL INFORMATION**
   By signing below, you agree to safeguard all Confidential Information (as defined below) of Riverside Healthcare Association, Inc. d/b/a Riverside Health System, its subsidiaries and affiliates (together, "RHS") to prevent unauthorized access and disclosure.

2. **DEFINITION OF CONFIDENTIAL INFORMATION**
   "***Confidential Information***" includes all patient, financial and strategic information that is proprietary to RHS, including but not limited to patient medical records, information contained in computer systems and servers, RHS trade secrets, and information that is developed for or on behalf of RHS by its employees, agents, contractors, consultants, vendors, volunteers, medical staff members, directors, officers, board members and any other persons for or on behalf of RHS ("***Person(s)***"). Confidential Information also includes Individually Identifiable Health Information (as defined in RHS Policy - Minimum Necessary Standard for the Use and Disclosure of PHI) and RHS proprietary information, whether in the form of a paper record, microfilm, computer data, reports, conversations, mail (either electronic or paper), a picture, graphic or multimedia representation. Confidential Information includes any information that RHS (or any Person as a result of their relationship to RHS) is contractually or legally required to keep confidential.

3. **YOUR OBLIGATIONS**
   By signing below, you agree to the following with respect to Confidential Information and RHS systems:
   a. You will dispose of Confidential Information in a responsible manner so as not to risk a breach in privacy or security, in accordance with RHS policies as applicable.
   b. You will not release Confidential Information to anyone who does not have a legitimate Need to Know the information in relation to an Authorized Activity. For Protected Health Information ("***PHI***"), apply the Minimum Necessary standard.
      (1) An "***Authorized Activity***" is necessary to complete your responsibilities as a volunteer, intern, or student at RHS, or for other lawful purposes authorized by RHS.
      (2) "***Need to Know***" is the principle that states that a user should access only the specific information necessary for the person's Authorized Activity.
      (3) "***Minimum Necessary***" is the smallest amount of PHI needed to accomplish the purpose(s) of a request for use or disclosure.
   c. You will not access any information outside of your area or responsibility and/or Authorized Activity. Use of computer software, files, and records is strictly limited to Authorized Activity on a Need-to-Know basis.
   d. You will not use RHS internet or email systems for purposes that are not authorized, appropriate, or consistent with RHS policies. You further understand that you have no right or expectation of privacy in your use of RHS internet or intranet, RHS systems, RHS-owned devices or any RHS electronic communication resources.
   e. You will not cause damage, corruption, or inappropriate deletion, or prevent rightful access to or unauthorized copying, of any information asset or computer programs.
   f. RHS may provide you with a User-ID and password. Your computer security User-ID and password are your means of access to various RHS computer systems and software, and they are confidential. You will not provide or surrender passwords to any other persons or use another person's User-ID or password. You will not allow any other person to use your RHS badge and will return your badge immediately upon RHS request.
   g. You will log-out after use of an application and/or RHS computer system and will not leave a workstation unattended for any period of time that might allow unauthorized persons to gain access to Confidential Information.
   h. You will take reasonable steps to prevent the misuse, theft, or improper access or disclosure of Confidential Information.
   i. You will not tamper with or engage in unauthorized duplication of any RHS computer hardware or software.
   j. You will not install unauthorized software or hardware on any RHS computer.

4. **REPORTING A BREACH**
   a. You will report breaches of privacy to the Compliance Office for RHS at privacy.support@rivhs.com or 757-534-6764.
   b. You will report breaches of security to the RHS Helpdesk, at 757-534-7104.
   c. You also have the option to report any security or privacy concerns to the compliance hotline at 1-800-303-5678.

5. **SANCTIONS**
   Failing to meet the obligations outlined above or accessing Confidential Information without a Need to Know may result in sanctions, up to and including revocation of computer privileges and/or access to RHS systems, administrative, civil and/or criminal sanctions, dismissal from RHS, and possible legal action.

6. **PROPERTY OF RHS**
   RHS may take appropriate action to verify that Confidential Information is not being accessed or disclosed in an unauthorized manner, and to ensure that systems are not being used or abused in any manner not authorized by RHS.

***By signing below, I agree to abide by this Agreement.***

**Signature:** _____ **Date of Signature:** _____

**Name** (*Please Print*): _____ **SSN** (last 4 digits): _____

**School/Program:** Virginia Peninsula Community College **Status** (Volunteer/Student/Intern): student

**Assigned Location:** _____

## RIVERSIDE HEALTH SYSTEM – COVID-19 Affiliation Participation Notice

During the COVID-19 pandemic, Riverside Health System (RHS) continues to be committed to protecting the health of our patients, families, visitors and staff. RHS has been welcoming back affiliated schools and students since early June 2020, to schedule and hold clinical rotations. It is RHS expectation that students and affiliated instructors follow standard precautions and www.CDC.gov recommendations to protect themselves and decrease the spread of infections while in our facilities.

Students/Instructors are **NOT permitted** to participate in care activities or procedures for suspected or known COVID-19 patients or aerosol-generating procedures (AGPs).

Students/Instructors **must not** report for participation in a rotation if ill or have any of the following symptoms:

| | | |
|---|---|---|
| Cough | Sore throat | Loss of taste or smell |
| Shortness of breath or difficulty breathing | Muscle or body aches | Congestion or runny nose |
| Fever (> 100.4) | Fatigue | Nausea or vomiting |
| Chills | Headache | Diarrhea |

Students/Instructors **must not** report for participation in a rotation **if any of the following situations apply:**

- You are currently under evaluation for a COVID-19 exposure.
- You have been diagnosed with COVID-19 and have not yet been cleared to discontinue isolation.
- You have had close, prolonged contact with a confirmed COVID-19 positive person (*outside of a safeguarded work environment*).

Students/Instructors will follow standard precautions and www.CDC.gov recommendations by:

- Masks must be worn at all times in the facility. Students should arrive on their first clinical day with a school-provided, new surgical or procedure mask and a brown paper bag with labeled with their name & school. Masks should be maintained in the bag between rotations and reused as possible. Masks that become wet, torn, or soiled during the rotation will be replaced by the RHS facility/department.
- Students must arrive with their own personal goggles. Goggles should be labeled with the student's name and school. Goggles are to be cleaned and maintained by the student as soiled and at the end of each shift.
- Masks and goggles must be worn for all Medical/Surgical patient encounters and throughout the rotation.
- IF the student has been approved for an Emergency Dept. or Surgical Dept. rotation, RHS-fitted, and provided N95masks must be worn at all times (rotation availability is limited).
- Students are not to be assigned to known COVID+ patients, identified PUIs (*Patients Under Investigation*), or participate in aerosolizing procedures that require N95 or P100 masks.
- As individuals do not wear masks while eating/drinking, all students must eat their meals in an area with a minimum of6 feet physical distancing between any other individual. It is recommended to eat outside, in personal vehicles, and avoid all breakrooms or group environments while masks are off.

Please sign and date this notice **as an attestation of understanding and additional expectations**.

**Signature:** _____ **School:** Virginia Peninsula Community College

**Name** (*Please Print*): _____ **Date:** _____

***Return signed notice to your school Program Coordinator for submission to Riverside Education Contracts Department.***