Dear Summer Student Healthcare Observation Program Participant:

Thank you for expressing interest in the program. We are excited that you are willing to learn more as you complete your Student Shadow experience. We will be accepting applications through Thursday, May 3, 2012. Student applicants must be 15 by June 1st to participate in the program. There will be two sessions held this year with mandatory orientation for each. Parent or Guardian must attend orientation with student. Reference forms should be mailed or faxed directly to Karli Stroh at INTEGRIS Canadian Valley Hospital by Thursday, May 3, 2012. Please do not turn in or mail the reference forms yourself. Staff will notify you of the student assignment. A limited number of student assignments are available and we may not be able to accommodate every request. It is imperative that all forms are completed and turned in by the deadline.

Attached you will find a Non-clinical (Non-paid) Student Internship / Externship / Shadow Application and the Disclosure and Authorization Regarding Procurement of Consumer Report (Background Check authorization) form. Please complete both forms and return to the Volunteer/Community Service Office.

INTEGRIS Health will require proof of the following prior to beginning the program:

- A copy of current health immunization records including:
  - Tuberculosis (TB) Screening, (must have two (2): one (1) within the last year and one (1) within the last ninety (90) days)
  - Rubella titer or immunization
  - Rubeola titer or immunization
  - Mumps titer or immunization
  - Varicella titer or immunization or Immunization or positive history of having Chicken Pox (provide dates if possible)
  - Influenza immunization (2011-2012 season)

Health immunizations records can be obtained from either your physician’s office or the City-County Health Department. Please note this request can take several weeks so do not delay in requesting copies of your records. It is your responsibility to obtain these records.

Sincerely,

The Human Resources Department at INTEGRIS Health
Non-clinical (Non-paid) Student Internship / Externship / Shadow Application

Name: ____________________________________________
                         (Last)                           (First)                          (M.I.)

Address: _______________________________________________
                         (Street)                                (City)
                       (State)                         (Zip)

Home Phone Number: ______________________ Cell Number: ______________________________

Email: ____________________ Social Security #:____________ Date of Birth:___________

Emergency Contact: ____________________________ Phone Number: ______________________

Please complete the appropriate section below:

☐  Related to INTEGRIS Health employee?  _____NO _____YES

If YES, state employee name and relation:  Name: ___________________ Relation: ___________

____________________________________________________________________________________
____________________________________________________________________________________

____________________________________________________________________________________

ACTIVITIES –

Please list school, professional, organizational activities/teams or volunteer services in which you have participated within the last 2 years: (Example: Volunteer work, community service projects, church activities, school activities/clubs, etc.) Attach list if needed.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

REFERENCES –

Please list the names, address and telephone numbers of two references and complete the attached reference forms.

1. ____________________________________________  (Name)  ______________________________ (Telephone Number)

2. ____________________________________________  (Name)  ______________________________ (Telephone Number)
Please choose **one** session to participate in. Choose up to 3 full days to participate in one session but no more than 3 days. Days will begin at 9:00 am and end 4:00 pm. Lunch will be from 12:00 p.m. to 1:00 p.m. Orientation will be held at INTEGRIS Canadian Valley Hospital Conference Room A/B.

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**Session One: June 11, 2012 to June 20, 2012**

- **Monday, June 11**
- **Tuesday, June 12**
- **Wednesday, June 13**
- **Thursday, June 14**
- **Friday, June 15**
- **Monday, June 18**
- **Tuesday, June 19**
- **Wednesday, June 20**

**Orientation: May 30, 2012 at 5:30 pm**

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**Session Two: July 16, 2012 to July 25, 2012**

- **Monday, July 16**
- **Tuesday, July 17**
- **Wednesday, July 18**
- **Thursday, July 19**
- **Friday, July 20**
- **Monday, July 23**
- **Tuesday, July 24**
- **Wednesday, July 25**

**Orientation: June 28, 2012 at 5:30 pm**

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**Service Area:** Please rank the service areas of your interest with 1 being highest priority and 8 being lowest priority. You may only stay in one department for 2 out of the 3 days you are here.

- **Medical/Surgical Unit**
- **Radiology**
- **Women’s Center**
- **Surgery**
- **Emergency Department**
- **Respiratory**
- **Physical Therapy**
- **Registration/MedicalRecords**

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Students must understand they are expected to have good attendance, maintain confidentiality at all times, follow hospital and program policies and behave properly or they will not be allowed to continue in the program. **Dress Code:** Students will be required to wear Business attire or scrubs. No jeans, leggings, shorts, dresses or skirts above the knee, or capri's will be allowed. Student must wear close-toed shoes (no sandals or flip-flops).

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I, ______________________ (name) understand that I will be expected to have good attendance, maintain confidentiality at all times, follow the hospital and student program policies and behave properly or I will not be allowed to continue in the student program.

(Student Signature) ____________________________________________ (Date) ______________________________________________________________________

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Please complete below if the student is under the age of (18) eighteen.

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(Parent/Guardian Signature) ___________________________ (Date) ______________________________________________________________________
Reference Form

To be completed by: _____________________________ Position: _____________________________

School / Organization: ___________________________ Phone: ___________________________

Applicant’s Name: ______________________________________________________________

The applicant listed above is applying for our Student Healthcare Observation Program. As part of this program the applicant may be assigned to work with hospital staff and patients and will require the student to behave appropriately, be courteous and be able to maintain confidentiality. Please complete the information below regarding your experiences and observations during the time you have known the applicant.

How do you know the applicant? __________________________________________________

How long have you known the applicant? ____________________________________________

Please rate the applicant on the following behaviors / traits using the rating scale below.

A = Excellent     B = Good     C = Average     D = Below Average     F = Poor

1. Punctuality – Arrives on time and completes work and assignments on time. _______

2. Shows respect for others. Is pleasant and courteous to acquaintances and strangers. _______

3. Follows through and is able to fulfill a commitment, assignment or agreement. _______

4. Follows directions. Obey organization / school policies and rules. _______

5. Behaves appropriately when supervised and also while they are unsupervised. _______

6. Able to keep information confidential. Does not gossip or spread rumors. _______

Please list any additional information you feel we should know about this applicant.

_____________________________________________________________________________

_____________________________________________________________________________

Signature: ______________________________ Date: ______________________________

Thank you for your honesty and participation in completing this reference form. Please mail this form to INTEGRIS Canadian Valley Hospital, Attn: Karli Stroh, 1201 Health Center Parkway, Yukon, OK 73099 or you may fax to 717-7964. Reference forms are due by May 3, 2012.
Reference Form

To be completed by: _____________________________  Position: __________________________

School / Organization: ______________________________  Phone: ___________________

Applicant’s Name: ______________________________________________________________

The applicant listed above is applying for our Student Healthcare Observation Program. As part of this program the applicant may be assigned to work with hospital staff and patients and will require the student to behave appropriately, be courteous and be able to maintain confidentiality. Please complete the information below regarding your experiences and observations during the time you have known the applicant.

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4. Follows directions. Obeys organization / school policies and rules. _______

5. Behaves appropriately when supervised and also while they are unsupervised. _______

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Please list any additional information you feel we should know about this applicant.

_________________________________________

Signature: _____________________________  Date: __________________________

Thank you for your honesty and participation in completing this reference form. Please mail this form to INTEGRIS Canadian Valley Hospital, Attn: Karli Stroh, 1201 Health Center Parkway, Yukon, OK 73099 or you may fax to 717-7964. **Reference forms are due by May 3, 2012.**
STUDENT/INSTRUCTOR CONFIDENTIALITY AGREEMENT

This Confidentiality Agreement is effective the ___ day of ____________, ____ between INTEGRIS Health, Inc. ("Facility") and ______________________________ ("Student/Instructor" or “Participant”). Participant agrees as follows:

Confidentiality: Participant acknowledges that as a result of the Clinical Rotations, he/she may have access to confidential information, including the identities of patients. To the extent allowed by law, Participant shall hold confidential all patient and Facility information obtained as Participant in these activities and not to disclose any personal, medical, or related information to third parties, family members, other students, or teachers. Participant is committed to protect and safeguard from any oral and written disclosure all confidential information with which he/she may come in contact. Participant shall not be permitted to copy and/or have access to patient medical records except as permitted by Facility. Except as permitted or required by this Agreement or by law, Participant will not use or disclose patient information in a manner that would violate the applicable requirements of the Privacy and Security Standards contained in the Health Insurance Portability and Accountability Act of 1996 and its regulations ("HIPAA"), which are incorporated herein by reference. Participant expressly agrees to comply with the applicable provisions of HIPAA in all respects, including the implementation of all necessary safeguards to prevent such disclosure. Participant acknowledges that any breach of confidentiality or misuse of information may result in termination of Participant's access to Facility, the potential termination of Facility's relationship with Participant's school and/or legal action. Unauthorized disclosure may give rise to legal liability for Participant.

Compliance with Policies and Rules: Participant shall abide by all applicable rules, policies, and instructions provided by Facility, whether verbal or written, while participating in the Clinical Rotations. Participant shall review the INTEGRIS Health Emergency Preparedness Information Brochure, as provided by Facility, which includes information regarding bloodborne pathogens, hazardous chemicals, TB prevention, fire safety, electrical safety, and emergency preparedness. Participant agrees to wear appropriate attire, including an identification badge identifying him/her as a Participant, if requested by Facility.

Release: Participant shall, to the extent allowed by law, hold harmless Facility, its parent INTEGRIS Health, Inc., and any and all of their affiliates, subsidiaries, employees, agents, and insurers (collectively "INTEGRIS"), from any and all liability of whatsoever nature and from injuries, sickness, or other damages, physical as well as emotional, suffered by Participant during participation in the Clinical Rotations, unless caused by INTEGRIS' negligence.

Limitation: Participant understands that by signing this Agreement, Participant is not guaranteed participation in any clinical activities at Facility. Facility in its sole discretion shall determine eligibility to participate.

Withdrawal of Unsatisfactory Participant: Facility may require the Participant to withdraw immediately from Clinical Rotations if the Participant's conduct, demeanor or cooperation is unsatisfactory to Facility as determined by Facility in its sole discretion.

Declaration: Participant declares that s/he is not required to register pursuant to either the Oklahoma Sex Offenders Registration Act or the Mary Rippy Violent Crime Offenders Registration Act.

Date: ___________________________    Participant: ________________________________
DISCLOSURE AND AUTHORIZATION REGARDING PROCUREMENT OF CONSUMER REPORT

In connection with my participation in an unpaid internship with INTEGRIS Health ("INTEGRIS"), I hereby authorize INTEGRIS, through its employees, representatives, agents, and independent contractors, now or at any time while I am participating in the Internship, to obtain from a consumer reporting agency a copy of a consumer and/or investigative consumer report on me (in accordance with the federal Fair Credit Reporting Act, as amended, and state law).

I further authorize INTEGRIS to conduct a comprehensive review of my background including public record information, criminal records, motor vehicle records, credit, bankruptcy proceedings, workers’ compensation claims, names and dates of previous employers, reason for termination, employment and work experience, a general background investigation, and any other searches or investigations that INTEGRIS deems necessary to confirm, determine, or evaluate my prior employment, military status, academic background, character, and general reputation. All information obtained pursuant to this Disclosure and Authorization shall be utilized to determine my eligibility for participation and continued participation in the Internship, as the case may be.

I also authorize and direct all individuals and entities, including without limitation all schools, businesses, corporations, credit bureaus, law enforcement agencies, armed forces, employment commissions, and governmental agencies to release any and all information without restriction or qualification pursuant to this Disclosure and Authorization. A photocopy or facsimile of this Disclosure and Authorization form shall be considered as effective and valid as the original.

Should a consumer report be requested, you have the right to receive a copy of the consumer report. Please check the box below if you wish to receive a copy of such report.

☐ I wish to obtain a copy of any consumer report obtained about me.

Student Signature ____________________________________________ Date __________________

Print Student Name ____________________________________________

Guardian Signature ____________________________________________ Date __________________

Previous Student Names (maiden name, aliases, etc.) _________________________________________

Student SSN _______________________________ Date of Birth (MM/DD/YYYY) ___________________

Current Address:
_____________________________________________________________________________________
_____________________________________________________________________________________

Previous Address(es):
_____________________________________________________________________________________
_____________________________________________________________________________________