Visiting Student Application

Date: ____________________

Type of Student (Medical, NP, PA): ______________________________

BASIC INFORMATION:

Badge # (if applicable): ____________________

Name: ____
Last First Middle Initial

Address: ____
Street City State Zip

Last 4 Digits of SS#:____________ Email Address: ______________________________

DOB:________________________ Cell Phone: _________________________

IN CASE OF EMERGENCY:

Name ____

Phone (home)____________________(cell)_____________________(relationship) _________________

SCHOOL/PROGRAM INFORMATION

Name of School & Program (if applicable): ____

School Address: ____

Contact person:______________________________Title_____________________________________

Phone/Email/Fax: ____

TRINITY HEALTH – PRECEPTOR (if placement is already secured)

Name: ____ Title: _________________________

Email: ____ Phone: ________________________

REQUESTED ROTATIONS

_______________________________ Start/End Dates: ___________________________________

_______________________________ Start/End Dates: ___________________________________

_______________________________ Start/End Dates: ___________________________________

__STUDENT LEARNER/PARENT/GUARDIAN AGREEMENT__

1. Maintain regular attendance in school (if applicable) and on the job; follow all rules concerning the program, and notify the school and Trinity Health prior to any absence.
2. Be honest, punctual, cooperative, dress appropriately and have a willingness to learn.
3. Consult program coordinator or Trinity Health about any problems and about termination of participation.
4. Conform to the rule and regulations of the worksite, including confidentiality.
5. Complete required assignments and furnish necessary information, reports, and time sheets.
6. Arrange transportation to and from worksite.
7. Provide necessary information such as signed consent and immunization records to include updates.
8. Agree to release or provide school transcript.
9. I have read the Participation Agreement carefully and have had sufficient opportunity to ask questions and have it explained to me before signing this application.
10. The Educational Affiliation Agreement that my school has with Trinity Health is available for me to read upon request.

EMPLOYER AGREEMENT

1. Provide thorough orientation to the job, worksite and safety instruction as well as a meaningful, positive, well-supervised work experience.
2. Provide evaluation of performance, consultation, and on-site monitoring visits by authorized staff.
3. Keep and complete accurate attendance and/or time records, as required.
4. Consult the program coordinator/teacher regarding problems related to the work experience.
5. Fill out the Employer's Report of Injury in the event of any accident, however, minor, which occurs on the job.
6. Agrees to provide a complete progress report for each agreed upon time frame as required.
7. Agrees to provide a consultation with school/program coordinator prior to terminating a student/learner relationship as required.

I, the undersigned, agree to the terms and conditions of this agreement:
All parties will conform to all federal, state, and local laws and regulations, including non-discrimination against any individual because of race, color, age, sex, religion, marital status, national origin, ancestry, or handicap.

____ __________________
Signature Date

EXHIBIT A

HOSPITAL
CLINICAL EXPERIENCE PARTICIPATION AGREEMENT

I,**______________________**(“Student”), in consideration for participating in the clinical training provided by Trinity Health (“Hospital”) and through my participation in Hospital's clinical training program, hereby agree to the following:

1. Patient Confidentiality. I understand that the health information of Hospital’s patients is confidential which means that it cannot be revealed or discussed with other patients, friends, relatives, or anyone else outside of the Hospital care environment. In other words, a patient’s personal and medical information can only be discussed in private with appropriate individuals who have a medical and/or business related need to know, whether on duty or off. **I hereby certify that I will not release or disclose patient information, unless my job requires it, and then I will disclose only the minimum necessary patient information needed to carry out my responsibilities for Hospital.**

2. Non-employee Status. I acknowledge that the clinical training received by me from Hospital shall be received as a student of School, as a part of my professional training, and not as an employee of Hospital. **I understand that as a participant in this clinical training program, I shall not be entitled to compensation or employee benefits, nor shall I be considered an employee of Hospital for purposes of unemployment compensation, minimum wage laws, workers' compensation, income tax withholding, Social Security, or any other purpose.**

3. Compliance with Policies. I will comply with all applicable standards of care, policies, procedures, rules and regulations of Hospital, and the instructions of Hospital supervisors. I will further observe conservative and professionally appropriate modes of dress, behavior and grooming at all times.

4. Participation. I will participate in clinical training in accordance with the instructions of Hospital supervisors.

5. Required Tests. I will provide a TB skin test and/or chest x-ray as required by the Hospital, and such other health-related testing and immunizations as may be required by Hospital or by the Michigan Department of Public Health or the Occupational Health and Safety Administration. I understand that if I refuse any required immunizations or health-related testing, I may be terminated from the clinical training program at Hospital. In the event, however, that I refuse the Hepatitis B vaccination, I will not be terminated from the Program if I promptly sign a written waiver expressly holding Hospital Harmless for any Hepatitis B exposure or infection that might result from clinical training at Hospital.

6. Release of Liability-Clinical Education Program. I understand and acknowledge that Hospital has the right to take certain actions, including but not limited to, the right to suspend or terminate me from, or limit my participation in, the clinical training program, or to

evaluate me unfavorably, if in its exclusive judgment I have failed to observe applicable policies, procedures, rules, regulations, or the instructions of Hospital supervisors, or have compromised the standard or quality of patient care or the safety of patients, or for other reasonable cause, including the failure to follow appropriate modes of dress, grooming and behavior. **I hereby voluntarily release Hospital and their employees, agents and medical staff from any and all liability based on such actions.**

7. Release of Liability-Academic Program. I understand and acknowledge that School shall have complete control over all academic aspects of the clinical training, including but not limited to, admissions, administration, faculty appointments, program design, grading, examinations and evaluations. **I hereby voluntarily release Hospital and their employees, agents and medical staff from any and all liability based on such actions.**

8. I have read this Participation Agreement carefully and have had sufficient opportunity to ask questions and have it explained to me before signing it.

____
Participant's Signature

____
Participant's Printed Name

Date:__________________

Trinity Health

Trinity Health Acceptable Use Acknowledgement

Background/Applicability

The following requirements apply to all non-public patient, colleague, and business information, including patient information (protected health information **("PHI")**) ("Confidential Information"). The requirements apply to Confidential Information in electronic, paper, and oral forms (any form). Confidential Information includes information of Trinity Health and all its affiliated and controlled healthcare organizations. The requirements apply to all computer systems, networks, or applications to which an authorized user has access, and which are used for Trinity Health activities. This includes third parties' and Trinity Health's computer systems, networks, and applications (collectively, the "Information Systems").

You must acknowledge agree to the following requirements as a condition of employment and/or being permitted to have access to (and logon credentials for) Information Systems. You are required to acknowledge that you understand the requirements. You also are required to agree that you are accountable to comply with Trinity Health's Acceptable Use Procedure.

Section 1: General Rules

- You agree to act in the best interest of Trinity Health. You agree to support compliance with federal and state laws and regulatory requirements including, but not limited to Health Insurance Portability and Accountability Act Laws and Regulations and updates and additions ("HIPAA").
- You agree to comply with the Trinity Health Acceptable Use Procedure.
- Trinity Health reserves the right to access, monitor, or disclose the information within its Information System and/or on its network as it deems necessary. Trinity Health may disclose your activity to law enforcement officials and Trinity Health management without your consent or prior notice to you.
- Trinity Health, in its sole discretion, has the absolute right to terminate your access and use of Confidential Information and/or Information Systems at any time. Trinity Health may terminate your access and use, with or without notice, for any reason or no reason, without any liability to you.
- You agree to maintain a current contact phone number, text accessible cell phone number and personal email in Trinity Health identity data storage. Trinity Health may use your phone number if necessary for user identification. Trinity Health may contact you by text or voicemail to any phone number associated with your identity, including cell phone numbers, which could result in charges to you.

Section 2: Legal and Privacy

Permitted and Required Access, Use and Disclosure of Confidential Information- You agree to:

- Access, display, store, use or disclose PHI only for legitimate purposes of diagnosis, treatment, or obtaining payment for patient care or for healthcare operations. You agree to actions only as appropriate to your employment/role.
- Protect all Confidential Information to which you have access, or which you otherwise acquire, from loss, misuse, alteration, modification, or unauthorized disclosure or access.
- Appropriately dispose of Confidential Information in a manner that will prevent viewing or use

of the information. You agree never to discard paper documents or other materials containing Confidential Information in the trash unless they have been shredded.

Prohibited Access, Use and Disclosure of Confidential Information Requirements:

- Do not access, display, store, use or disclose Confidential Information in any form for personal reasons, or for any purpose not permitted by Trinity Health policies and procedures. This prohibition includes information about co-workers, family members, friends, neighbors, celebrities, or yourself. (**NOTE:** You must follow the required procedures at each applicable Ministry regarding gaining access to your own PHI in medical and other records.)
- Do not use another person's login ID, password, badges, or other method that enables access to the Information Systems or Confidential Information.
- When your employment or association with Trinity Health ends
  - Do not subsequently access any non-public Information Systems (other than as directed by Trinity Health for communication purposes).
  - Do not access, use, or disclose any Trinity Health Confidential Information
  - Promptly return any devices and other Trinity Health property
  - Appropriately dispose of Confidential Information
- Do not distribute, sell, market, or commercialize Trinity Health Confidential Information for personal gain.
- If your role requires distributing information outside of Trinity Health, do not send bulk emails (more than five) revealing the identity of the recipients (use 'blind copy' functionality).
- Do not access, disclose, or reproduce Trinity Health's Confidential Information outside of your job function/role.
- Do not access any Information Systems when located outside of the United States, except in accordance with the Trinity Health International Travel Policy.

Section 3: Information Security

Use of Trinity Health Computer Systems/Devices:

- Immediately report to the TIS Service Desk at 888-667-3003.
  - Suspected security events
  - Security policy violations (such as improper/unauthorized access to Trinity Health's Computer System)
  - Possible improper use or disclosure of Confidential Information (in electronic, paper, or oral forms)
  - Lost or stolen devices with access to Trinity Health's Information System or Confidential Information
- Use Trinity Health devices only for purposes permitted by Trinity Health
  - If in doubt about use of a Trinity Health device contact your supervisor or the TIS Service Desk.
- Care for and use Trinity Health devices in a secure and confidential manner.
  - Assure physical security for the devices.
  - Assure confidential storage of the devices.
  - Assure secure disclosure and access to Confidential and PHI Confidential Information

Only use Trinity Health computer systems/devices while traveling outside of the United States of America in accordance with the International Travel Policy.

Acceptable Use of Email, Network, and Internet

- Download, configure and use the approved security applications (currently Microsoft Authenticator) with your mobile device for secure remote access to the Trinity Health network.
- Encrypt Confidential Information when transmitted across non-Trinity Health networks.
- Use Trinity Health's email and other Information System resources only to perform job

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functions.
- In an emergency or unplanned situation, Trinity Health may suspend or terminate your access without advance warning to protect its Information System.
- Do not use Trinity Health's Information System or other network resources to harm, expose, or create legal liabilities by inappropriate use.

Password Use and Security
- Create, protect and use strong passwords, as described in Trinity Health's Acceptable Use Procedure.
- Use only your personally assigned user credentials and do not share your user credentials (e.g., login IDs, passwords, PINs, access codes, badges) with others for any reason.

Appropriate Software Use:
- Do not download non-Trinity Health sanctioned software/programs to Trinity Health devices.
- Use only Trinity Health approved software to conduct Trinity Health business and store Confidential Information.
- Do not make any changes to Trinity Health's Information Systems or devices without Trinity Health's prior written approval.

Information Protection
- Secure your workstation by locking screen or logging-off workstation when th device is not in use.
- Secure physical documents containing Confidential Information in a locked location when not in use.

Acknowledgement
- By typing or signing your name below, you hereby agree that: you have read this Acceptable Use Acknowledgement and Trinity Health's Acceptable Use Procedure and agree to abide by the requirements,
- you acknowledge that violation of Trinity Health's Acceptable Use Procedure or these requirements may lead to disciplinary action, up to and including termination, and
- you acknowledge that your access may be suspended or terminated and/or you may be personally liable for failure to comply and are subject to substantial civil damages and/or criminal penalties for any violation of these requirements.

If there are any items in these requirements that you do not understand, you agree to promptly ask your supervisor, employer, or sponsor for clarification.

Name of Employer or Sponsor: ____

Signature of individual to be given access: ________________________

Print Name: ________________________

Date: ________________________