

## **Return the Completed Forms to:**

**UCSD Extension**

**Lactation Education Coordinator**

**8950 Villa La Jolla Dr, Ste C215**

**La Jolla, CA 92037-1712**

**Voice: 858-964-1010, Fax: 858-964-1018, Email: [unexhealthcare@ucsd.edu](mailto:unexhealthcare@ucsd.edu)**

- (Sharp Healthcare) Placement Request Form***
- Signed Confidentiality and Non-disclosure Agreement (Signed)***
- Code of Conduct, Certification ([Click here to print](#))***
  - ([Click here to review](#) part 1)*
  - ([Click here to review](#) part 2)*
  - ([Click here to review](#) part 3)*
  - ([Click here to review](#) part 4)*

*All students must review materials and then submit Certification page.*
- Individual Malpractice Insurance in the amount of \$1 / 3 million***
  - \* Submit copy of insurance***
    - <http://www.nso.com> (RN's only)*
    - <http://www.hpsso.com> (As Medical Technician/Technologist)*
- Required Training Verification Form (Signed)***
- HIPPA Privacy Basics Posttest ([Click here for link](#))***
  - \*All students must review and submit posttest***
- Sharp HealthCare Compliance Education for Students***
  - ([Click here for link](#)) \*All students must review and submit posttest*
- Information Security Basics ([Click here for link](#))***
  - \*All students must review and submit posttest***

### **CONSULTANT Students only:**

- Drug Screen Results***
- Background Check Results***
  - [www.sharpbackground.com](http://www.sharpbackground.com) Package 1: Background Check and 10 Panel Drug Screen*
- Annual tuberculosis screening (Mantoux tuberculosis test)***
- Positive titer to rubella and rubeola or vaccination or a physician's statement***
- Tetanus***
- Varicella immunity***
- Vaccine/immunity Hepatitis B or signed declination form***
- Influenza immunization or signed declination form***
- CPR***

# SHARP

HEALTHCARE

## PLACEMENT REQUEST FORM

DATE:

(sharp: 01/01/07)

<b>SCHOOL NAME:</b> University of California, San Diego	
<b>STUDENT'S NAME:</b>	<b>STUDENT'S PHONE #:</b>
<b>INSTRUCTOR:</b> Gini Baker, RN, MPH, IBCLC	<b>INSTRUCTOR'S PHONE #:</b> 858-964-1010
<b>PROGRAM</b> Lactation Education	<b>COURSE #:</b> RMED-40016
<b>ROTATION WILL START:</b> Fall Quarter, Annually	<b>ROTATION WILL END:</b> Summer Quarter, Annually
<b>THE TOTAL NUMBER OF HOURS STUDENT NEEDS IS:</b> Varied	<b>WHAT SHIFT:</b> Determined by Facility
<b>DAYS AVAILABLE:</b> All	<b>PRECEPTOR'S NAME (if known):</b> Determined by Facility
<b>WHAT FACILITY :</b> Sharp, Mary Birch Hospital for Women Sharp, Chula Vista Sharp, Grossmont	<b>HAS PLACEMENT BEEN APPROVED BY THE SITE?</b> Yes <b>If so, who approved:</b> Susan Toth & Cindy Szold <b>PHONE NUMBER:</b>
<b>MANDATORY: (All Students and Instructors): Before starting rotation: Sharp HealthCare training modules for HIPAA, Corporate Integrity, Information Security and Sharp's Commitment to Principles must be read and completed.</b>	
<b>INSURANCE INFORMATION: (For clinical students) - A <u>certificate</u> of Professional Liability must be attached or on file at Sharp's SRN/Affiliation office - see address below.</b>	
<b>HEALTH SCREENING: (All students and instructors) It is the responsibility of the student and instructor to meet health screening requirements prior to beginning their rotation. Do not send health records.</b>	

The following is a check off list showing the items that need to be in compliance with before starting rotation.  
 REMINDER: Please DO NOT SEND health records - just check off the items on the list you are in compliance with.  
 Thank you.

(APPLIES TO ALL STUDENTS and INSTRUCTORS on site with students)

Check items in compliance:

	Annual tuberculosis screening: Mantoux tuberculosis test or if positive Health Departments guidelines for follow up.
	Positive titer to rubella and rubeola or vaccination against same or a physician's statement of disease concerning rubella and rubeola
	Immunizations: Tetanus
	Varicella immunity
	CPR - Will be required if the area the student is in requires it
	Vaccine/immunity Hepatitis B or signed declination form



## HEALTH TRAINEE

### Required Training Verification

**Name:** \_\_\_\_\_

**School:** University of California, San Diego

I have received, read and understand the following modules\*:

- HIPAA Privacy Training Basics
- Corporate Compliance
- Information Security

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

**Nicole Mitchell**  
\_\_\_\_\_  
**School Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

**Program Representative**  
**Title**

\*UCSD must receive copies of the post-tests to keep in student's file.

## CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

### Obligations Regarding Confidentiality

Applies to all employees (including administration, managers, supervisors and applicable physicians); volunteers; agency, temporary and registry personnel; students, interns, and contracted personnel.

Patient health and Sharp Organizational information is protected by law and by Sharp HealthCare policies. The intent of these laws and policies is to assure that confidentiality of information is maintained while used for business and clinical operations. In my job, I may see or hear confidential information in any form (oral, written, electronic) regarding:

- Patients and/or their family members (such as patient records, test results, conversations, financial information)
- Employees, physicians, volunteers and contractors (such as employment records, corrective action, disciplinary action)

#### I AGREE TO AND ACKNOWLEDGE THE FOLLOWING:

- I will protect the privacy of all business and medical information relating to our patients, members, employees and health care providers.
- I know that confidential information I learn on my job does not belong to me and I have no right or ownership to it. Sharp HealthCare may take away my access to confidential information at any time.
- I will not misuse confidential information and will only access information necessary to do my job. I will not disclose any confidential information unless required to do so in the official capacity of my relationship, employment or contract with Sharp HealthCare.
- I will not share, change or destroy any confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure or the instructions of my supervisor (such as shredding confidential paper). If a demand from an oversight agency, law enforcement or government agency is made upon me from outside Sharp HealthCare to disclose confidential information, I will document this by giving written notice to my supervisor.
- I will only print information from a Sharp HealthCare information system when necessary for a legitimate work related purpose. I am accountable for this information until it is properly filed or disposed of.
- If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am responsible to protect my password or other access to confidential information. I understand that my use of an electronic system may be periodically monitored and audited to ensure compliance with this agreement.
- I understand that I have an obligation to report to my supervisor and/or the Compliance Hotline if I think someone is misusing confidential information or is using my password. I further understand that Sharp HealthCare will not tolerate any retaliation against me for making a report.
- On termination of my employment, I will return to Sharp HealthCare all copies of documents containing Sharp HealthCare's confidential information or data in my possession or control.

I understand that failure to comply with this agreement may result in corrective action up to, and including, termination of employment or other relationships with Sharp HealthCare. I understand that I may also be subject to other remedies allowed by law. I understand that I must also comply with any laws, regulations, and Sharp HealthCare policies, including the Commitment to Principles, Privacy, Confidentiality and Security policies that address confidentiality. This agreement shall survive the termination of my official relationship, employment or contract with Sharp HealthCare.

I have read and understand this Confidentiality and Non-Disclosure Agreement, have had my questions fully addressed and have received a copy.

Date: \_\_\_\_\_  
Printed Name (Student) Signature

Date: \_\_\_\_\_  
Printed Name (School Witness) Signature