



LACTATION CONSULTANT PROGRAM – CLINICAL FORM

FOR INDIVIDUALS REQUESTING 150 HOURS OF CLINICAL TRAINING AS PART OF THE LACTATION CONSULTANT PROGRAM

INSTRUCTIONS:

This form must be completed, signed, and turned in at least 2 weeks prior to starting your clinical training time. Please send your completed form, and copies of all the requested information in Section B, to Gwen Wysocki, 11255 Mountain View Ave., Suite 11, Loma Linda, CA 92354. Or you may fax the information to Gwen at (909) 558-3541.

SECTION A – Please complete the following:

Please check and complete all that apply:
 Non-LLUMC Participant LLUMC Employee - ID # _____

Name (PRINT) _____ Phone _____
 Street Address _____
 City/State/Zip _____
 Current Employer _____
 Supervisor's Name _____ Phone _____
 Start Date of Clinical Training _____ Email Address _____

SECTION B – Please attach copies of the information below to this form:

- TB skin test results within the last 12 months. If positive PPD, a written chest x-ray clearance from your MD is required.
- Rubella titer or documentation of immunization. If you were born after January 1, 1957, you must show evidence of re-immunization.
- Copy of current CPR (Basic Life Support) certificate/card.
- Copy of health insurance coverage card.
- Copy of professional malpractice insurance coverage card.
- Copy of professional license for validation.
- Copy of recent background check clearance (if NOT currently employed with an employer who conducted a check)

SECTION C – Please read, then sign and date the statement below:

I agree to adhere to a strict code of confidentiality, both verbally and in written material. All information obtained from clients/patients, their records, or computerized data is to be held in confidence. No copies of client/patient records shall be made, and no records or computer printouts, or copies thereof are to be removed from the Medical Center or its facilities unless pre-approved authorization is obtained by designated personnel. If pre-authorization is obtained, all patient information must be de-identified. Clients/patients will not be identified in any manner in paper, reports, or case studies undertaken by me unless specifically authorized by IRB/Research Study.

As a clinical trainee, I hereby waive, release and forever discharge LLUMC and its affiliated entities, associates, partners, agents, employees and volunteers of and from any and all matters, claims and suits of every kind whatsoever which the above signed may have or which may hereafter accrue as a result of or in any way connected with participation in any observation at LLUMC or its affiliated entities. I further agree to assume any and all risks and to release and hold harmless LLUMC and its affiliated entities, associates, partners, agents, employees and volunteers who, through negligence, carelessness, or otherwise might be liable to the above signed for any personal injuries, loss, cost, wages and any and all other damage resulting from or connected to the above signed for participation in any observation.

In addition, my signature below indicates that I will read through the "Orientation Guide" booklet, and that I will take responsibility for the information contained in it.

Participant Signature _____ Date _____

THIS AREA FOR STAFF DEVELOPMENT USE ONLY

Approval Signature, Staff Development Manager of Academic Relations _____ Date _____

- Staff Development Perinatal Educator notified that completed paperwork was received.