Hamilton Health Care System
New Instructor Orientation Verification Form

PLEASE MAINTAIN THIS FORM ON FILE AT YOUR SCHOOL TEN YEARS

This form and all required documents and documentation must be completed no less than 14 business days prior to the start date for any Clinical Rotation, Preceptorship, or Internship.

Name of Instructor: _____ **Date:** _____
Name of school, university, or college: _____
Program of study: _____

Goal/Topic	Date Completed	Clinical Coordinator's Initials
Hamilton Healthcare Systems, INC: Mission, Vision, & Pledge		
Bloodborne Pathogens/ Infection Control		
Hospital Safety		
Management of information: HIPAA/Confidentiality (Read/Sign Agreement)		
Universal Responsibilities		
Conduct/Dress		
Smoking		
Parking		
HCAHPS Information Sheet		
Hospital National Patient Safety Goals		
Soarian Clinicals Student Nurse Reference Guide		

Completed paperwork must be turned into the Clinical Coordinator and signed before reporting for your clinical rotation.

I acknowledge that the items listed above were covered during orientation utilizing written materials, videos and/or presentations.

Instructor's Signature:_____**Date:**_____

DO NOT WRITE IN THIS BOX – FOR INSTRUCTOR USE ONLY

CLEARED FOR CLINICAL ROTATION TENATIVE START DATE_____

Background Check Complete (date)_____ Drug Screen Complete (date)_____

Immunization Records Complete (date)_____ Professional Insurance (date)_____

Verification of Health Exam (date)_____ Verification of CPR (date)_____

Clinical Coordinator's Signature:_____**Date:**_____

This information must be supplied.