Hamilton Health Care System
Student 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 Student:____________________________________Date: _______________
Name of school, university, or college: ______________________________________
Current standing (i.e., freshman, sophomore, etc.) ______________________________
Program of study: __________________________________

Goal/Topic	**Date Completed**	**Instructors 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		

Completed paperwork must be turned into your instructor and signed before reporting for your clinical rotation.

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

Student'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 AHA-BLS (date)_______________

Instructor's Signature:____Date:_________________

This information must be supplied.

Hamilton Health Care System
Student Sanctions Verification Form

Healthcare organizations that receive federal or state funds are required to verify that those providing or involved with services have not been excluded, debarred, or otherwise declared ineligible from participating in a federal or state healthcare program. This includes physicians, medical staff, employees, students, and volunteers.

Please fill in **all** sections below; if section not applicable, indicate with "NA".

The completion of this form serves as your agreement to allow Hamilton Health Care System to conduct the required monthly sanctions verification with the information you have provided. If you opt not to provide any of this information, you may be denied access to complete a clinical rotation, preceptorship or internship at Hamilton Health Care System.

First Name______________________ Middle Name____________________ Last Name______________________

Maiden Name (if applicable) _________________________Alternate or Nickname _____________________________

Date of Birth (mmddyyyy)____

Social Security Number (###-##-####) ____

Street Address of Residence____

City of Residence____

State of Residence____

Zip Code of Residence ____

NPI (if applicable) ____

Professional License # (if applicable) ____

I acknowledge that Hamilton Health Care System (Hamilton) will conduct a monthly sanctions verification during my clinical rotation, preceptorship or internship at Hamilton with the information that I have provided above and I attest that the information that I have provided is true and accurate.

Student's Signature:____Date:_____________

DO NOT WRITE IN THIS BOX – HAMILTON STAFF USE ONLY

Date Received ________________________________ Unique Identifier ______________________________

Date Entered in Netlearning ______________________________________