

Student Clinical Rotation Guidelines and Required Paperwork for Clearance

SCHOOL CERTIFICATION FORM (Pg 1 of 2)

SCHOOL CERTIFICATION OF HEALTH STATUS OF STUDENTS AND FACULTY MEMBERS PARTICIPATING IN CLINICAL ROTATIONS AT THE HOSPITAL

Baptist Health South Florida and (name of school) _____:

Program Name: _____

School certifies that the students and faculty members listed in the attached roster have completed the health status requirements listed below. School certifies that it maintains documented proof of the health status of all students and faculty members participating in clinical rotations at the Hospital, including but not limited to, evidence of examinations performed and documentation from a physician that such students and faculty members are free of communicable disease. Evidence of the following is maintained by School and available to Hospital upon request. In accordance with Section 2.2 of the Agreement, only students listed in the attached roster may participate in clinical rotations at the Hospital.

1. **Two tuberculin skin tests are required within one year before your clinical rotations at Baptist Health.** If you have not had a PPD test within the last year or lost proof of your test, you may be tested twice as long as it is within a 3-week time period but no more than one year. If the second PPD is positive, a chest x-ray must be taken and the result must be negative.
2. **Proof of Rubella and Rubeolla immunity** by positive antibody titers or two doses of MMR.
3. **Varicella immunity**, by positive history of chicken pox or proof of Varicella immunization.
4. **Proof of Hepatitis B immunization or completion of a certification of declination of vaccine.**
5. **Current CPR Healthcare Provider card** from the American Heart Association or the Red Cross.
6. Liability insurance coverage
7. **Certify compliance with HIPAA regulations** as outlined in section 4.4 of the Agreement.
8. **Read the Baptist Health Student and Faculty Handbook prior to the clinical rotations.**
9. **Faculty members** supervising students must have an **active Florida License** and **current CPR card.**
10. **Criminal background check** completed by the school **on all students.**

Course: _____ Ref #: _____ Rotation Dates: _____

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Course: _____ Ref #: _____ Rotation Dates: _____

Course: _____ Ref #: _____ Rotation Dates: _____

Print Name of Coordinator/Instructor Signature of Coordinator/Instructor Date

***Please attach roster of participating students.**

DO NOT SEND STUDENT OR FACULTY INFORMATION TO HOSPITAL.

Fax school certification and student roster to: **Jacqueline Davis, Student Affiliations**
Fax: 786-533-9795
Phone: 786-596-7534

*****Forms to be submitted a month prior to the beginning of the semester. *****

Notes:

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Guidelines for Undergraduate (RN-BSN), Graduate (MSN, NP, CRNA, DNP, PhD), and PA Students

The following information is required prior to beginning clinical experiences at a Baptist Health Facility. These guidelines apply to students working with on-site and/ or office based preceptors rounding through a Baptist Health Facility.

1. Prior to accommodating a student for preceptor ship, there must be a student affiliation agreement on file between the university and Baptist Health.
2. Only accept internships from accredited programs.
3. Students are responsible to seek out their internship opportunities.
4. All internships require prior approval from department manager or director.
5. All students are required to read and understand the student orientation handbook.

Required Documentation:

1. Signed and completed Baptist Health Certification Forms (pgs. 68-69)
2. Copy of current CPR card; include ACLS and PALS if available
3. Copy of RN license
4. Completed preceptor letter of agreement (pg. 71)
5. Completed internship placement information (pg.72)
6. **Required documentation submitted a month prior to the start date of the internship.**

Upon receipt of required documents, an email will be sent to the student, preceptor, university and department director clearing the student for their internship experience within Baptist Health. Students will not be cleared without completion of required documents. A copy of the required documents will be emailed to the department directors.

Submit completed forms to: Jacqueline Davis
BHSF Scholars Program
Contact Number: 786-596-7534
Email: JacquelineD@baptisthealth.net
Fax #: 786-533-9795

Notes:

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Medical Record Documentation Requirements:

- 1) NP and PA students are permitted to document on the patient's medical record. The chart shall be held by the student until the preceptor has reviewed and cosigned the student's documentation, orders and progress notes. Unsigned records are not to be left unattended until the MD/ARNP or PA preceptor has appropriately reviewed and co-signed the record.
- 2) Students shall sign the medical record with their name, NP or PA student, and the full name of their university (e.g. Maria Jones, NP student, Florida International University).
- 3) Please refer to preceptor's (ARNP or PA) Delineation of Privileges (DOP) as defined by the entity.

Notes:

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Preceptor Letter of Agreement For Undergraduate (RN-BSN), Graduate (MSN, NP, CRNA, DNP, PhD), and PA Students

I have read the materials provided by the university regarding the expected student learning experience. I agree to be a clinical preceptor for _____ (student name) from _____ (name of university) from _____ (date ranges). At the end of the experience, I will evaluate the student using the clinical evaluation forms provided to me from the university. If I have questions, I will contact the faculty member at the university responsible for the student.

Faculty Name: _____

Faculty Signature: _____

Faculty Email: _____

Faculty Contact Number: _____

Preceptor Name: _____
(Name and credentials)

Preceptor Signature: _____

Date: _____

Preceptor Email: _____

Preceptor Contact Number: _____

Internship Dept Manager or Above Name: _____

Internship Dept Manager or Above Signature: _____

Date: _____ Email: _____

Student Signature: _____

Notes:

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Internship Placement Information For

Undergraduate (RN-BSN), Graduate (MSN, NP, CRNA, DNP, PhD), and PA Students

Course Name and Number: _____

Student's Name _____

Student's Phone Number: _____

Student's Email: _____

Faculty Member Name: _____

Faculty Member Contact Number: _____

Faculty Member Email: _____

Preceptor's Name and Credentials: _____

Clinical Site Facility: _____

Preceptor's Contact Number: _____

Preceptor's Contact Email: _____

Notes: