APPLICATION TO CENTRACARE FOR STUDENT ROTATION EXPERIENCE ***FAMILY MEDICINE RESIDENCY PROGRAM***

Name: _____ Date: _____
First *MI* *Last*

Address: _____ City, State, Zip: _____

Date of Birth: _____ U.S.A. Citizen: ☐ Yes ☐ No

Phone #: _____ E-mail address: _____

Local emergency contact: _____
Name *Phone #*

School Name/Location: _____ Program: ☐ MD ☐ DO

Year in school for this rotation: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th Expected date of graduation: _____

School Contact Name: _____

E-mail address: _____ Phone # _____

Educational Experience:

Undergraduate/Graduate School(s):

Name/Location:	Dates (mo/yr):	Degree:
1. _____	_____	_____
2. _____	_____	_____

Medical School(s) (list all previous medical school attended):

Name/Location:	Dates (mo/yr):
1. _____	_____
2. _____	_____

Has your medical education been interrupted or extended, or have you remediated any coursework? ☐ No ☐ Yes

If yes, explain: _____

USMLE/COMLEX Information (Include information on all attempts):

Step 1:	Total # of Attempts: _____	Three Digit Score(s): _____	
Step 2 CK/CE:	Total # of Attempts: _____	Three Digit Score(s): _____	☐ Not Attempted Yet
Step 2 CS/PE:	Total # of Attempts: _____	☐ Pass ☐ Fail	☐ Not Attempted Yet

Dates of Desired Rotation (start and end dates):

1st choice (start & end dates): _____

2nd choice (start & end dates): _____

3rd choice (start & end dates): _____

Desired Experiences: ☐ Inpatient Family Medicine ☐ Outpatient Family Medicine ☐ Both Inpatient and Outpatient

Do you need housing while you are here? ○ No ○ Yes

Additional Information:

Did someone recommend our clerkship rotation? Referral name:

_____

How did you hear about our program?

_____

_____

What are your objectives for this rotation?

_____

How does this rotation fit into your overall educational goals?

_____

Once out of medical school and residency, what kind of practice do you envision having?

_____

_____

What interest do you have in St. Cloud, MN/CentraCare Health System?

_____

Do you have any connections to the area?

_____

MD/DO - Do you have an interest in applying here for our Family Medicine Residency program? ☐ No ☐ Yes

Any misdemeanor or felony convictions in the U.S.: ☐ No ☐ Yes If yes, explain: _____

Have you had training and or experience with gowning, gloving, sterile field? ☐ No ☐ Yes

If yes, describe: _____

Have you had experience with the Epic electronic medical record system? ☐ No ☐ Yes

If yes, when did you last use Epic (month/year)?

_____

a. Which applications or in what work environment did you use Epic?
   ☐ Clinic ☐ Hospital Inpatient ☐ Hospital Outpatient ☐ ER ☐ Surgery
b. What key functions did you perform in Epic system?
   ☐ Enter orders in Epic ☐ Phases of Care ☐ Add entries to the patient Problem List
   ☐ Update patient Medication List ☐ Use In Basket ☐ Use SmartTools to Document in Patient Chart

Student: complete and return the following forms and requested documentation to the Medical Staff Office at St. Cloud Hospital. All items below are required and must be submitted in their entirety with application.

- Application Form
- Confidentiality Form
- Drug and Alcohol Acknowledgment Form
- Program Representative Attestation Form
- Evidence of receiving flu vaccine for current flu season if rotation dates are between October 1st through March31st
- Rotation objectives from school that pertain to specific rotation (1-2 page max)

I, THE STUDENT, UNDERSTAND THEFOLLOWING:

- *Objectives must be consistent with the CentraCare mission and values.*
- *All communication regarding possible rotations/questions must be between the "school" and CentraCare.*
- *An Affiliation Agreement must be signed and current between the school/program and CentraCare.*
- *All forms/requirements must be submitted at the same time. Applications with missing documentation will not be considered.*
- *Submission of application and required documentation does not guarantee approval of the rotation. CentraCare will notify the program representative if the requested rotation has been approved or if they are unable to accommodate a rotation.*
- *Rotation requests from APP applicants who are not currently employed by CentraCare will be considered starting 3 months prior to the requested start date.*
- *Only one rotation may be assigned per applicant due to the high demand for preceptors.*
- *This application is only for a CentraCare facility and does not pertain to a non-CentraCare site.*
- *I will report all clinical hours for this rotation to my school and it will match what I report to CentraCare.*
- *If accepted for rotation, I will need to complete Epic training and online education/orientation modules.*
- *It is a requirement to wear the ID badge provided by CentraCare at all times during the rotation at CentraCare site(s). The ID badge must be returned to the Security Office or the site contact on the last day of the rotation. If after hours, the ID badge should be given to the preceptor.*
- *Cell phone use during the rotation period is prohibited.*
- *I must read and comply with the CentraCare Dress Code Policy.*
- *It is my responsibility to declare if pregnant during the rotation experience. (Rotation/observation in certain areas may not be allowed if pregnant.)*
- *In the event of an illness or injury while at a CentraCare site, emergency care will be provided in the Emergency Room associated with the CentraCare site at my full expense; or I may go to my personal physician at my full expense.*
- *The school/program must email MSOMedStudents@centracare.comcontact the St. Cloud Hospital Medical Staff Office one month prior to start of rotation for cancelation. The cancelation will not open a spot for a different applicant from the same program.*
- *I allow CentraCare to share my application and all material provided by me or my school with all CentraCare entities.*

Applicant's signature _____ Date _____

Please e-mail the entire completed packet/requirements to Ashley.Davis@centracare.com . The Residency Support Office will notify you within 1-3 weeks if your application has been approved.

CONFIDENTIALITY AGREEMENT

I,_____(print name), an employee, independent contractor, student, or volunteer of CentraCare Health, or its affiliates or divisions ("Organization") have read the Confidentiality Policy of the Organization, understand my responsibility under the Confidentiality Policy to, patients, employees, and co-workers, have been trained about the significance of confidentiality and agree not to breach the Confidentiality Policy.

I will not access Protected Health Information (PHI) that I do not need to perform my job responsibilities.

I will not inappropriately divulge medical information that I have obtained in the course of my job responsibilities.

I understand that I cannot access my family's medical record by using the Organization's computer system. As an employee and/or physician I may view my own medical record to the extent that my individual access rights allow within the computer system. For information beyond the scope of my access rights I must work with the appropriate Medical Information department or request to see my medical record through my primary care provider.

I understand that a breach of confidentiality will subject me to disciplinary action by the Organization, which may include immediate termination of employment, and may subject me to legal action. I understand that the disciplinary action would become part of my personnel file.

A breach occurs in the following instances, which are not intended to include all situations:

- Discussing any information pertaining to patients with anyone (including my own family) who is not directly involved with such patients.
- Discussing or displaying any information pertaining to patients where it can be overheard or seen by anyone not directly involved with such patients, including other patients and their families. (Examples: elevators, outside patient exam rooms, computer screens.)
- Describing patient behavior, which has been observed or learned through my affiliation with the Organization.
- Sharing or failing to properly protect computer passwords or other information authorizing or providing access to systems containing PHI.
- Transmitting patient information to any individual, entity, or agency outside the Organization, except as authorized by law.
- Displaying or posting patient information via a social networking site such as, but not limited to, Facebook, Twitter, etc.
- Discussing with a patient his or her treatment, condition, or visit at the clinic outside of the continuum of care, unless initiated by the patient and the discussion is not susceptible to being overheard by others. (Example: approaching a patient in a restaurant, at church or at an event.)
- Maintaining a therapeutic relationship with a patient during off-duty hours without prior authorization.
- Attempting to obtain, accessing, divulging, or further disseminating medical information retained by the Organization regarding employees, co-workers, acquaintances, family members.

I will have access to medical records belonging to Epic Connect Customers. I will only access those records as part of my defined job responsibilities and will abide by CentraCare's privacy and confidentiality policies when accessing these records. I understand patient information should not be stored on a computer's hard drive or on removable storage devices, including but not limited to CD's, DVD's, USB sticks, and portable hard drives. I will not access information from the computer inappropriately. I also understand that any access I make in the computer can be tracked and logged and may be periodically audited without notice. I understand this document will become part of my personnel file.

_____ _____

SIGNATURE DATE

9/13

St. Cloud Hospital Student

Drug and Alcohol Acknowledgment

St. Cloud Hospital is committed to maintaining a work environment, which is free from the influence of alcohol and/or drugs to protect the health, safety, and well-being of our patients, employees, and visitors.

St. Cloud Hospital prohibits the use, possession, transfer, and sale of alcohol or illegal drugs by all students or interns while working learning experience(s) on all premises owned, leased, or otherwise controlled by St. Cloud Hospital, while operating any St. Cloud Hospital equipment, machinery, or vehicle. It also prohibits reporting for work learning experiences under the influence of alcohol and/or drugs. This policy does not apply to students who are solely on the premises for the purpose of receiving medical treatment or visiting a person who is receiving medical treatment.

If St. Cloud Hospital forms a reasonable suspicion that a student has/is using, possessing, transferring or selling alcohol or illegal drugs in violation of the above-stated policy, the student may be tested, at the St. Cloud Hospital's expense, pursuant to St. Cloud Hospital's employee and volunteer drug and alcohol testing policy. If the test results are confirmed positive, the student will be subject to appropriate disciplinary action, up to and including termination from the St. Cloud Hospital's student program.

Any cost of confirmatory retesting shall be borne by the student. The student is also responsible for cost associated with any follow-up treatment, including chemical dependency evaluation or treatment.

I hereby certify that I have read this Acknowledgement and fully understand and agree to abide by its contents.

_____

Signature of Student

_____ _____

Student's Printed Name Date

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PROGRAM REPRESENTATIVE ATTESTATION FORM FOR ALL STUDENTS

By signing this form, I (Program Representative), attest that…

The following immunizations are currently on file with the School/Program (see next page for full descriptions):

- 2-step TB skin test (TST/Mantoux).
- 2 documented MMR immunizations, or proof of immunity (titer).
- 2 documented chicken pox (varicella) immunizations, or proof of immunity (titer), or medical statement from healthcare provider of clinic visit when applicant was seen and diagnosed with Varicella or Zoster (shingles).
- 3 documented Hepatitis B vaccinations, or 2 documented Heplisav-B vaccinations, or proof of immunity (titer), or completed declination form.
- Tdap vaccination after age 11.

The following **is or will be** on file prior to the start of the student's rotation (see next page for full descriptions):

- Minnesota Department of Human Services (DHS) Background Study (completed within the immediate 12 months preceding the applicant's initial Educational Experience and needs to remain valid throughout duration of assignment).
  **If report shows applicant is not in good standing or there is a change in validity, I will notify CentraCare immediately.
- Negative 7-panel Urine Drug **and** Alcohol Testing (within the three months prior to the applicant's initial Educational Experience at CentraCare or admission to their program. Tests will need to be repeated for applicants who leave School and return at a later date).
- Current registered nurse licensure in the State of Minnesota (for NP, CNS, CNM, & CRNA applicants).
- Current AHA Basic Life Support Healthcare Provider card (for PA, NP, CNS, CNM, and CRNA applicants).

I will submit a hard copy of the applicant's annual flu vaccine documentation for the current season to CentraCare by October 1st.

This program is accredited by an organization that is recognized by the Department of Education, the Centers for Medicare and Medicaid Services, or another national body that reviews the accrediting organizations for multiple disciplines.

The "Advanced Practice Provider School Prioritization for Student Clinical Rotations Guidelines" has been reviewed (included on page 6 of this application).

If APRN program, applicant has had 2 years of RN experience prior to admittance to academic program (requirement for student rotation).

Do not send hard copies of the above requirements (with the exception of the flu vaccine documentation). If you are unable to attest to all requirements listed above, you must obtain these records from the applicant and file them within the applicant's record at your facility prior to completing this form. Compliance with the above requirements is needed for the duration of the rotation and the duration of additional rotations. A description of each of the requirements is found following the attestation form and in Exhibit 2 of the affiliation agreement.

Please select appropriate response:

APRN program has _____ total patient facing hours requirement (select appropriate range). ***Patient facing hours exclude DNP project work
Students with 650 or less patient facing hours are not eligible for a rotation.

○ 1000+ ○ 750-999 ○ 651-749 ○ N/A

PA program has _____ total patient facing hours requirement (select appropriate range).
Students with less than 2000 patient facing hours are not eligible for a rotation UNLESS they have 2+ years of medial experience.

○ 2000+ ○ 2+ yrs Med Experience ○ N/A

APP Program Details (*CentraCare will not be partnering with solely online programs or providing rotations to students who enroll in exclusively online programs. Must have on-campus component requirement.)*

○ On Campus ○ Online + On Campus ○ Online only

Proximity of school to CentraCare sites:

○ Within MN ○ Within WI, IA, SD, ND ○ Other

Has this applicant completed other rotations at CentraCare?

○ Yes ○ No

Student's program is from a Minnesota MERC grant sponsoring institution. (Please see next page for additional information.)

○ Yes ○ No

I attest that all information submitted is true and correct, agree to keep and maintain documentation evidencing compliance with the above listed requirements, agree to provide documentation evidencing compliance with the above listed requirements to CentraCare within 24 hours upon CentraCare's request per the affiliation agreement, and understand that if the above requirements are not met, maintained, or provided upon the requested deadline, CentraCare shall have the right to deny the rotation request and/or require the School/Program to remove any student/resident from the educational experience at CentraCare. Such a decision to request removal of a student/resident or faculty from the educational experience is in the sole discretion of CentraCare and shall not be subject to consideration or reconsideration by any other person or entity.

Name of Applicant: _____ Date enrolled in this program: _____

Program Representative Signature: _____ Date: _____

Program Representative Printed Name: _____ Title: _____

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ADDITIONAL ATTESTATION FORM INFORMATION

1. A State of Minnesota Department of Human Services (DHS) NETStudy 2.0 Background Study result is required. It is the responsibility of the School to request the background study on behalf of the applicant. No other background studies will be accepted, such as CertifiedBackgrounds, QualifiedFirst, etc.

   Minnesota Department of Human Services
   P.O. Box 64172 Saint Paul, Minnesota, 55164-0172
   O: 651-431-6625
   F: 651-431-7694
   E: dhs.netstudy2@state.mn.us
   https://mn.gov/dhs/

2. Urine and Alcohol Testing:
   - 7-panel drug screen includes: Amphetamines, Cannabinoids, Cocaine, Phencyclidine, Opiates, Barbiturates , Benzodiazepines, plus alcohol with adulterants testing.
   - If not yet completed for current program, the applicant should wait to complete the Urine and Alcohol testing until after rotation availability is determined, as rotations are not guaranteed.
   - Urine and Alcohol Testing from 7-panel drug screen may be conducted at the Midwest Occupational Medicine (320) 251-9675, Workmed Midwest (www.workmedmidwest.com), or Mid-Minnesota Drug Testing, Inc. (320) 230-8378.
   - The applicant may also contact any occupational health clinic that runs the Urine and Alcohol Testing from a 7-panel drug screen. Applicants are responsible for ensuring that the clinic/lab they work with conducts the correct test.

3. Two-step Tuberculin Skin Test (TST/TB)/Mantoux:
   - Prior to participating in the Educational Experience, the applicant must complete a two-step baseline TST.
   - The first step must be completed within 90 days of starting the educational program or observation experience per MN Department of Health. The 2nd TST should be within 21 days of the first. If a previous negative TST was done in the past 12 months, that can be considered the second TST.
   - A TB blood test (e.g. Quantiferon-TB Gold, T-SPOT) may be utilized in place of TST if completed within 90 days of rotation.
   - Following the two step TST/TB/Mantoux test, yearly testing is required.
   - If applicant has a positive Mantoux history, a negative chest x-ray can be accepted, along with a completed TB Symptom Form (provided by CentraCare upon request).

4. MMR and Varicella:
   - If the applicant does not have evidence of 2 MMR and 2 Varicella immunizations, a positive titer will need to be provided.
   - If the applicant has a negative titer, completion of the immunization series is required. Please note, there is a 28-day waiting period between the first vaccine and the second vaccine. If both MMR and Varicella vaccines need to be completed, they must be done at the same time to avoid further delay.

5. Evidence of 3 Hepatitis B vaccinations, 2 Heplisav-B vaccinations, a positive titer, or completion of the declination form (provided by CentraCare) is required.

6. Evidence of receiving Pertussis (Tdap) vaccination after age 11 is required. (This is not tetanus/Td.)

7. Influenza vaccination documentation is required for all students/residents who will be on-site between October 1 – April 30. Students/Residents who do not receive the flu vaccination are required to wear a mask at all times in areas where patients may be present. Failure to either submit evidence of immunization or comply with CentraCare policy to wear a mask if not vaccinated may result in loss of clinical time or termination of experience.

8. **Minnesota MERC grant sponsoring institutions:** Students attending MERC sponsoring institutions are required to accurately log each day of their rotation by recording the date, time, location, and name of the preceptor on the time card that is provided within their clearance email. Completed time cards are required to be provided to the St. Cloud Hospital Medical Staff Office within 1 week of the last date of the student's experience. If the student is at more than one location in a day or with more than one preceptor, each location and/or preceptor must be recorded separately. **All MN schools are encouraged to participate in the Medical Education and Research Cost (MERC) Grant for Sponsoring Institutions and Teaching Programs.**
   https://www.health.state.mn.us/facilities/ruralhealth/merc/index.html