OhioHealth Summer Research Externship Program Goals:

The Summer Research Externship Program at OhioHealth is a program designed to give medical students a broad understanding of clinical research and quality improvement as well as provide exposure to graduate medical education programs.

OhioHealth Summer Research Externship Program Description:

Applicants to the program should be first year medical students in good standing with their schools. Selected externs will work with assigned faculty members from our Ohio teaching hospitals on new or in-progress quality improvement or research projects. Specific duties include participation in introductory research lectures and may include literature searches, protocol review, patient interaction, data collection, data analysis and assisting with preparation/presentation of conference-quality posters or manuscripts describing the research. Students will also spend time in the clinical environment at their assigned site.

- Students are expected to work full time during the program.
- Begins May 27, 2025 and continues through July 18, 2025.
  The first week includes Research Didactics and attendance is required for all externs.
- Externs will receive a weekly stipend while enrolled in the OHSREP.
- During the last week of the program, students will present their findings at Student Research Day

Application Window:

Applications will be accepted from ***November 28, 2024 – January 8, 2025***.
Applications submitted outside of the application window will not be considered.

Directions:

1. Please be sure to thoroughly read and complete the application in its entirety.
2. Send completed application to SREP@OhioHealth.com
   a. Attach the following along with your application:
      i. Cover Letter
      ii. Curriculum Vitea
      iii. Professional Photo

OhioHealth
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2025 OhioHealth Summer Research Externship Program Application

SECTION A: Applicant Information

Name: ____
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Email: ____

Cell Phone: ____

Hometown: ____

Medical School: ____

First Year Medical School: □ I am a first-year medical student. □ I am not a first-year medical student.

Academic Standing: □ I am in good academic and professional standing.

Area of Interest: ____

Other: ____

Preferred Location: ____

SECTION B: Cover Letter

Please submit a Cover Letter for the selection committee to review along with your application. Please answer the questions below:

1. Why are you interested in the Summer Research Externship Program at OhioHealth?
2. Do you have any previous research experience? If so, explain.
3. Explain the "why" behind your areas of research interest.
4. How would this program benefit you as a future physician?

SECTION C: Student Acknowledgement

I acknowledge that during my clinical experience at any OhioHealth facility, I will receive, generate, consider and use information which is confidential in nature. I understand that the unauthorized dissemination of confidential information may be harmful to OhioHealth and/or to the patients or others served by OhioHealth facilities. I agree to maintain the confidentiality of such information and not to discuss the same except as permitted by OhioHealth policy and applicable law. **I also understand that I am not permitted to start my research project at any OhioHealth facility until I have completed all assigned regulatory modules and received an OhioHealth student ID Badge.**

____ ____________________
Signature **Date**

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Print Name (First, MI, Last)

Confidentiality Statement of Understanding and Internet Use Agreement

This statement summarizes the responsibilities and obligations of all persons who use, create or receive confidential information through any affiliation with OhioHealth, as set out in OhioHealth's Privacy Policy. This statement further serves to inform workforce members of the expectations and responsibilities regarding appropriate internet use when representing OhioHealth or utilizing OhioHealth resources. The scope of this statement covers all OhioHealth "workforce members" defined to include (but not limited to): employees, volunteers, trainees, contractors, employed physicians (including residents), non-employed physicians, and associated staff that may access OhioHealth confidential information for patient care or healthcare operations, and other persons whose conduct, in the performance of work for OhioHealth, is under the direct control of OhioHealth, whether or not the person is paid by OhioHealth.

I understand and acknowledge that:

- It is my legal and ethical responsibility to protect the privacy, confidentiality, and security of all confidential or sensitive information including, but not limited to, Protected Health Information (patient-identifiable information) and Health Care Business Information such as proprietary business, associate, or provider information.
- I will not, at any time during or after my employment or affiliation with OhioHealth, improperly use, disclose to any person, or store any confidential information, nor will I permit any unauthorized person to examine or make copies of any reports, documents, or on-line information that comes into my possession. Confidential information is made available on a need to know basis and is limited to the minimum necessary requirement, and thus, I will not access confidential information without authorization, and I will do so only when I am required to do so for specific business purposes.
- Unauthorized disclosure of confidential information is totally prohibited.
- Disclosure of or sharing of passwords, access codes, and hardware token devices assigned to me (my "Access Credentials") is prohibited. I am accountable for my Access Credentials and for any improper access to information gained through use of my Access Credentials. My Access Credentials are the equivalent of my legal signature, and I shall take all reasonable and necessary steps to protect my Access Credentials. I am responsible for all actions taken using my Access Credentials. If I have reason to believe that the confidentiality of my Access Credentials or the confidentiality of my staff's credentials has been broken, I shall immediately notify the OhioHealth Director of Information Security.
- If I utilize a personal electronic device to access confidential information, I will ensure that all confidential information accessed through the device will be afforded the protections required by federal, state, and local laws and regulations. It is my responsibility to apply the required and indicated technical, physical, and administrative safeguards to such devices. Such safeguards include but are not limited to: encryption, password protection, anti-virus software, not leaving my devices unattended, and locking and logging off the device after my use. Further guidance on such safeguards can be found in OhioHealth Policies and Procedures.
- OhioHealth assumes no responsibility for the use, maintenance, support, or potential damages that may be incurred with any personal devices used to access OhioHealth confidential information.
- If a personal device used to access Protected Health Information is lost or stolen, I will immediately report such incident to the OhioHealth Privacy Officer at 866-411-6181 or via mycompliancereport.com (Access ID: OHH).
- Internet access and use on an OhioHealth network should be limited to business purposes, and personal use should be minimized. Inappropriate activity includes but is not limited to: utilizing an OhioHealth internet connection for activities that are not directly related to a business purpose of OhioHealth; activities that are illegal or intended to circumvent applicable laws and regulations; activities that could lead to accusations of unethical behavior or damage OhioHealth's professional reputation.
- I will immediately report any suspicious activity (e.g. unexplained appearances of new files, corrupted files, access by unauthorized staff, and access to inappropriate websites) or any computers that are suspected of being compromised by malicious attack to the OhioHealth Director of Information Security.
- I will not divulge confidential information to unknown sources without proper identification, authorization, and confirmation of identity.
- I understand that I may use "cloud" applications and servers (such as Evernote and Dropbox) only for educational purposes and presentations I am giving. In conjunction with my use of cloud applications, I may not use, upload, or share (i) any Protected Health Information or (ii) any confidential and proprietary business information of or from OhioHealth; and that I will not, at any time, identify OhioHealth Corporation as the source of such information.
- If I violate any of the above statements, I may lose my access privileges immediately and may be subject to corrective actions up to and including termination.

By signing below, I acknowledge I have read and understand the foregoing information, and I agree to comply with the above terms.

____ ____________________
Signature **Date**

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Print Name (First, MI, Last)