OhioHealth Advanced Practice Provider Student Application

Thank you for choosing OhioHealth to be a part of your educational experience.

APPLICATION WINDOWS

Complete applications must be submitted by school program coordinators in the appropriate application window. Applications submitted outside of the application window will not be considered.

If you are planning to extend a rotation, a new application packet is required during the appropriate application window.

Application Submission Windows		
Clinical Term	Applications Accepted Starting	Application Deadline
Spring Semester January 1 – April 30	October 1	November 1
Summer Semester May 1 – July 31	February 1	March 1
Fall Semester August 1 – December 31	May 1	June 1

*Appy during the semester in which your start date falls

DIRECTIONS

1. Please be sure to thoroughly read and complete every section of this application.
2. Complete sections A – C and sign the bottom of page 3.
3. Complete Section D student section only.
4. Give the application to your school program coordinator to complete the Section D school representative section.
    a. The school program coordinator will send completed applications to appstudent@ohiohealth.com.

Incomplete applications will not be processed and will result in a denial of your clinical rotation request. Applications will only be accepted from school representatives. Applications will not be accepted directly from students.

Copies of additional items DO NOT need to be submitted with this application. Please return only the application, signed Confidentiality Statement, Section D form, and a current resume.

Desired Location of Rotation		
CENTRAL REGION ❑ HOSPITALS (Doctors, Dublin, Grant, Riverside, Grove City) ❑ Freestanding Emergency Departments ❑ OhioHealth Outpatient Offices ❑ Employer Services ❑ Urgent Care	**NORTHERN REGION** ❑ HOSPITALS (Grady, Mansfield/Shelby, Marion General, Hardin) ❑ NW Hospitals (Van Wert) ❑ Freestanding Emergency Departments ❑ OhioHealth Outpatient Offices, including Marion Area Physicians ❑ Urgent Care	**SOUTHERN REGION** ❑ HOSPITALS (O'Bleness, Berger) ❑ OhioHealth Outpatient Offices ❑ Freestanding Emergency Departments **EASTERN REGION** ❑ Southeastern Medical Center

If you have any questions or concerns regarding the APP student application, please contact: appstudent@ohiohealth.com

OhioHealth
BELIEVE IN *WE*™

OhioHealth Advanced Practice Provider Student Application

Date: _____ **School** _____

SECTION A: Applicant Information

Name: _____
Last First MI

Email: _____

Expected Graduation Date: _____ **How many clinical rotations have you completed to date in your current academic program?** _____

Employment Status (if applicable)

❑ I am a current OhioHealth Associate – OPID: _____

❑ I am a former OhioHealth Associate – Location and End Date: _____

❑ I have an OhioHealth Student OPID: _____

Student Status

What type of Student are you:

❑ NP - Type _____
❑ CNS - Type _____
❑ PMHNP Year-long Preceptorship ONLY (apply in January)
❑ Physician Assistant
❑ Certified Nurse Midwife

I can rotate with the following types of preceptors:

❑ Clinical Nurse Specialist
❑ Psychiatric-Mental Health NP
❑ Certified Nurse Midwife
❑ Acute Care Pediatric NP
❑ Adult Gerontology Acute Care NP
❑ Adult Gerontology Primary Care NP
❑ Family NP
❑ Neonatal NP
❑ Pediatric Primary Care NP
❑ Physician Assistant
❑ Women's Health NP
❑ MD, DO

Preceptor Information / Request

❑ I have been in contact with a CNP, CNS, PA, CNM, and/or physician at OhioHealth and he/she has **agreed** to precept me during my clinical rotation at OhioHealth. **ALL CONTACT INFORMATION REQUESTED IS REQUIRED.**

Preceptor Name:		Preceptor email:			
Phone:		Manager email:			
Campus/Facility:		Department:			
Start Date (MM/DD/YY):	____/____/____	End Date (MM/DD):	____/____/____	# of Hours	
2nd Preceptor Name:		Preceptor email:			
Phone:		Manager email:			
Campus/Facility:		Department:			
Start Date:	____/____/____	End Date (MM/DD):	____/____/____	# of Hours	
3rd Preceptor Name:		Preceptor email:			
Phone:		Manager email:			
Campus/Facility:		Department:			
Start Date:	____/____/____	End Date (MM/DD):	____/____/____	# of Hours	

Please Note: The dates above determine your computer and ID badge access. If you are doing more than one rotation please indicate the MULTIPLE dates that will cover ALL of your rotations as to not interrupt your computer and ID badge access. **A new application must be submitted for each application window.**

❑ **I DO NOT have a preceptor** and would like to be placed with one for my clinical rotation at OhioHealth. I understand that there is no guarantee of preceptor placement.

☐ I am can rotate within a **hospital (inpatient)**
☐ I am can rotate within an **ambulatory (outpatient) setting**

I need or am interested in a rotation in the following specialties (check all that apply)
Check "Any" only if you can rotate with ANY specialty available

❑ ANY INPATIENT SPECIALTY
❑ ANY OUTPATIENT SPECIALTY

❑ Primary Care
❑ Internal Medicine
❑ Women's Health (OB/GYN)
❑ Pediatrics
❑ Behavioral Health
❑ Cardiology
❑ Employer Services
❑ Hospice
❑ Hospital Medicine
❑ Neurology
❑ Oncology
❑ Orthopedics
❑ Palliative Care
❑ Pulmonary
❑ Surgery/Critical Care
❑ Trauma
❑ Urology
❑ Urgent Care
❑ Wound
❑ Other _____
❑ Other _____

Start Date (MM/DD/YY):_____ End Date (MM/DD/YY):_____ Number of Hours Needed: _____

Second rotation during same term if applicable:

Start Date (MM/DD/YY):_____ End Date (MM/DD/YY):_____ Number of Hours Needed: _____

Please Note: The dates above determine your computer and ID badge access. You will not have computer access until the earliest date you have selected above. Your access will be immediately discontinued on the last date you have selected above. If you are doing more than one rotation please indicate the MULTIPLE dates that will cover ALL of your rotations as to not interrupt your computer and ID badge access. **A new application must be submitted for each application window.**

SECTION B: School Affiliation Agreement Information

❑ This school has a current Affiliation Agreement with OhioHealth.
❑ This school does not have a current Affiliation Agreement with OhioHealth.
❑ Affiliation Agreement status unknown

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 rotating at any OhioHealth facility until I have completed all assigned regulatory modules and received an OhioHealth student ID Badge.**

Signature: _____ **Date:** _____

Printed Name: _____

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**

_____

Print Name (First, MI, Last)

SECTION D: Required Additional Items

To be completed by Student

Expired items will not be accepted

❑ The student's Driver's license or government issued ID_____(ID Number)_____(Expiration date)

❑ I had a negative TB skin test on_____(date). *Skin test results expire after one year.*

OR I have had a positive TB test, and my last chest x-ray was_____(date).

Latent TB Chest X-Rays results are acceptable unless symptoms of TB are present.

❑ The student's last flu shot was given on_____(date must be within current flu season).

❑ The student's CPR card was issued on _____ (date) and expires on _____ (date).

❑ Preferred email address:_____

❑ Resume (**please attach**)

❑ Signed Confidentiality Statement of Understanding and Internet User Agreement (attached).

To be completed by School Representative

It is the responsibility of the school to ensure that students maintain unexpired documents as required in this document and that the above information provided by the student is accurate. Copies do not need to be submitted to OhioHealth at this time unless requested.

☐ I acknowledge_____ (student name) is enrolled at _____ (institution), and that this student is currently in good academic standing.

❑ Our institution holds malpractice insurance with the company. Our policy is effective until _____ (date)-

_____ _____
School Representative Signature **Date**

_____
Print Name (First, MI, Last)

_____
Title

_____
Phone Number **Email Address**