Fairfield Medical Center

STUDENT APPLICATION

PERSONAL

Student Name _____ Phone # _____

Address_____ Cell # _____

City/State/Zip _____ Email _____

If under 18 yrs of age, please check box ☐

REQUEST

Please complete:

Hrs _____ Department(s)

_____Dates_____

Have you made contact w/this department? Y N Dept. Contact Name _____

Are you currently employed/volunteer or have you ever been employed/volunteered at Fairfield Medical Center or any of its affiliate in any capacity? Y N

If yes, date_____ and department _____

SCHOOL

School Name _____ Instructor _____

Instructor Email_____ Phone_____

Program of Study_____ Expected Graduation Date_____

In consideration of my student experience at Fairfield Medical Center, I agree to conform to the rules and regulations of this facility. I understand that my experience can be terminated at any time and for any reason, at the option of either the facility, the school or myself. I understand that this student experience does not enter me into an agreement of employment with this facility. I hereby affirm that the information provided on this application (and accompanying resume, if any) is true and complete. I understand that any false or misleading representations or omissions may disqualify me from this student experience and further disqualify me from consideration for employment. I hereby authorize persons, school, and employers named in this application (resume, if any) to provide this facility with any relevant information regarding my student experience, and I release all such persons from any liability regarding the provision or use of such information.

Signature _____ Date _____

My typed name above shall have the same force and effect as my written signature.

Please include a copy of your resume with your completed application.

Email to Jill Kennedy at jillk@fmchealth.org or by mail to:

Jill Kennedy, Staff Development
Fairfield Medical Center
401 North Ewing Street
Lancaster, Ohio 43130

CONFIDENTIALITY STATEMENT/WAIVER/RELEASE

TO BE SIGNED BY EACH STUDENT AS A CONDITION OF PARTICIPATION IN ANY STUDENT/INTERN/SHADOW EXPERIENCE

I. CONFIDENTIALITY STATEMENT

I understand that as a student completing my internship/shadowing experience at Fairfield Medical Center ("the Hospital"), I may be exposed to confidential information regarding patients and financial information produced by or held by the Hospital. During the term of my visit with the Hospital and any related activities, or any time thereafter, I shall not directly or indirectly, make or cause to be made, any disclosure or other use not authorized by the Hospital of any confidential information acquired during the course of my experience at the Hospital unless such information is or becomes otherwise legally available to the public. For purposes of this agreement, the term "confidential information" means any business, medical or financial information not generally known to the public at large regarding the business and operations of the Hospital and its patients, employees and physicians. Any breach of confidential information by me shall constitute grounds for immediate termination from my internship/shadowing experience at the Hospital and can further be grounds for any legal action taken by the offended parties.

II. WAIVER OF LIABILITY/RELEASE WITH ASSUMPTION OF RISK AND INDEMNIFICATION

In exchange for the agreement of the Hospital to permit participation in any student/intern/shadow experience, I hereby voluntarily assume the risk of injury and waive, release, and agree to hold harmless and indemnify the Hospital, its employees and agents from any and all liability, arising from negligence or otherwise, and all damages in any way resulting from participation in any student/intern/shadow experience at the Hospital, including but not limited to bodily, personal, or mental injury.

The undersigned, has read the above carefully, understand its significance, and voluntarily agree to all of its terms.

_____ _____

Student Date

If student is under 18 years of age, the student's parent or guardian must also sign.

_____ _____

Parent or Guardian of Student Date

_____ _____

Parent or Guardian of Student Date

Notes: All required signatures (both parents for a student under the age of 18 unless only one parent has legal custody) must be completed and this form must be properly returned before the Student may participate.

Please send original copy to Jill Kennedy , R.N. Fairfield Medical Center, 401 N. Ewing Street, Lancaster, Ohio 43130.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, I acknowledge that I am in receipt of Fairfield Medical Center's Notice of Privacy Practices.

Date: _____

_____
Student Signature

_____
Student Name (printed)

For Department use only: date received_____

Application w/signature: yes__ no__	Privacy signature: yes___ no___
Liability signature: yes___ no___	Orientation post-test: yes___ no___
Immunizations verification: yes__ no___ n/a__	Background verification: yes___ no___ n/a___
Current school contract: yes___ no___	Placement: yes___ no___
Preceptor:_____	HR notified: yes___ no___