



STUDENT APPLICATION

PERSONAL	Student Name _____	Phone # _____
	Address _____	Cell # _____
	City/State/Zip _____	Email _____

REQUEST	Please complete:	
	# Hrs _____	
	Department(s) _____	Dates _____
	Have you made contact w/this department? Y N Dept. Contact Name _____	
	Are you currently employed by Fairfield Medical Center or any of its affiliate in any capacity? Y N	
	If yes, hire 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

CONTINUED ON BACK....

FMC USE ONLY	Dept. _____	Employee Responsible _____	Ext. _____
	Badge # _____	Parking Tag # _____	TB Test V _____ CPR V _____
	App Rec'd _____	Post-test Rec'd _____	Resume Rec'd _____ Syllabus Rec'd _____ School Contract _____
	Evaluation Sent: Student _____ Mgr _____ Consider for hire? Y N		

FAIRFIELD MEDICAL CENTER

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to Fairfield Medical Center located at 401 North Ewing Street, Lancaster, Ohio composed of:

- **Diagnostic Health Services** located at 1159 East Main Street, Lancaster
- **Diagnostic Health Services, Carroll Office**, located at 82 East Canal Street, Carroll
- **Diagnostic Health Services, Colonnade Office**, located at 1550 Sheridan Drive, Suite 302, Lancaster
- **Diagnostic Health Services, Granville Pike Office**, located at 1781 Countryside Drive, Lancaster
- **Ewing Square Specialty Services** located at 1253 East Main Street, Lancaster
- **Fairfield Center for Health & Healing** located at 1356 River Valley Boulevard, Lancaster
- **Fairfield Medical Center Business Office** located at 1153 East Main Street, Lancaster
- **Fairfield Medical Center Lab - River Valley** located at 1203B River Valley Boulevard, Lancaster
- **Millersport Diagnostic Health Services** located at 12135 Lancaster Street, Millersport
- **Outpatient Therapy Services** located at 1143 East Main Street, Lancaster
- **Surgery Pavilion** located at 135 North Ewing Street, Lancaster
- **The Wellness Center at the Robert K. Fox Family Y** located at 465 West Sixth Avenue, Lancaster
- **The physicians and other licensed professionals seeing and treating patients at Fairfield Medical Center and its associates.**

The members of this clinically integrated health care arrangement work and practice at Fairfield Medical Center. All of the entities and persons listed will share personal health information of our patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notices by submitting a request to the Medical Records Department.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures For Treatment. We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you. For instance, if, after you leave the hospital, you are going to receive home health care, we may release your personal health information to that home health agency so that a plan of care can be prepared for you.

Uses and Disclosures For Payment. We will make uses and disclosures of your personal health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services since company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment. We may also provide your personal health information to our collection agency, if necessary, to collect payment for services provided to you.

Uses and Disclosures For Health Care Operations. We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Our Facility Directory. We maintain a facility directory listing your name, room number, general condition and, if you wish, your religious affiliation. Unless you choose to have your information excluded from this directory, the information, excluding your religious affiliation, will be disclosed to anyone who requests it by asking for you by name. This information, including your religious affiliation, may be provided to members of the clergy. You have the right to have your information excluded from this directory at any time.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. We may also disclose limited health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Fundraising. We may contact you to donate to a fundraising effort for or on our behalf. You have the right to "opt-out" of receiving fundraising materials/communications and may do so by sending your name and address to the Marketing Department together with a statement that you do not wish to receive fundraising materials or communications from us.

Appointments and Services. We may contact you to provide appointment reminders and/or test results. You have the right to request and we will accommodate reasonable request by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders not to be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to the Medical Records Department.

Health Products and Services. We may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research. In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of all patients that receive a particular drug and will need to review a series of medical records. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Confidentiality of Alcohol and Drug Abuse Patient Records. The Confidentiality of alcohol and drug abuse patient records maintained by this facility is protected by federal law and regulations. Generally, the facility may not say to a person outside the program that you attend a drug or alcohol program, or disclose any information identifying you as an alcohol or drug abuser unless: (1) you consent in writing; (2) the disclosure is allowed by a court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation. Federal law and regulations do not protect any information about a crime committed by you either at our facility or against any person who works for the facility or about any threat to commit such a crime. Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

- We may release your personal health information for any purpose required by law
- We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations
- We may release your personal health information as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence
- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls
- We may release your personal health information to your employer when we have provided health care to you at the request of your employer to determine workplace-related illness or injury; in most cases you will receive notice that information is disclosed to your employer
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings
- We may release your personal health information if required to do so by subpoena or discovery request; in some cases you will have notice of such release
- We may release your personal health information to law enforcement officials as required by law to report wounds and injuries and crimes
- We may release your personal health information to coroners and/or funeral directors consistent with law
- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you
- We may release your personal health information if in limited instances if we suspect a serious threat to health or safety
- We may release your personal health information if you are a member of the military as required by armed forces services we may also release your personal health information if necessary for national security or intelligence activities
- We may release your personal health information to workers' compensation agencies if necessary for your workers' compensation benefit determination Ohio law requires that we obtain a consent from you before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. Requests for access may be made verbally or in writing to the Medical Records Department and require an authorization for release of information signed by you or your legal representative. If you request a copy of the information, we will charge you as follows:

- No records search fee
- For data recorded on paper:
 - \$2.67 per page for the first 10 pages
 - \$ 0.55 per page for pages 11 through 50
 - \$ 0.22 per page, for pages 51 and higher

Fee schedule for a person/entity other than a patient or patients personal representative (for example an attorney or insurance company):

- \$16.38 records search fee
- For data recorded on paper:
 - \$1.08 per page for the first 10 pages
 - \$0.55 per page for pages 11 through 50
 - \$0.22 per page for pages 51 and higher

Chart reviews will also be scheduled with the Medical Records Department and will be charged at \$10.00 (records reviewed within the department). There is no charge for the copying and release of your health information when it is released to another health care provider for continuity of care.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reason for the amendment/correction request. If an amendment or correction to your request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from the Medical Records Department at Fairfield Medical Center.

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Medical Records Department at Fairfield Medical Center. The first accounting in any 12-month period is free; you will be charged a fee of \$15.00 for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations. A restriction request form can be obtained from the Medical Records Department at Fairfield Medical Center. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, an agreed-to restriction by sending such termination notice to the Medical Records Department at Fairfield Medical Center.

Complaints. If you believe your privacy rights have been violated, you can file a complaint in writing to the Privacy Officer at 401 North Ewing Street, Lancaster, Ohio 43130. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgment of Receipt of Notice. You will be asked to sign an acknowledgment form that you received this Notice of Privacy Practices.

FURTHER INFORMATION If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer at (740) 687-8011. As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE This Notice of Privacy Practices is effective April 14, 2003.

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.

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)

WAIVER OF LIABILITY/RELEASE WITH ASSUMPTION OF RISK AND INDEMNIFICATION

In exchange for the agreement of the Fairfield Medical Center ("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.

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