Fairfield
Medical Center

Student Onboarding Requirements

(On page 3 is a list of all required documents needed)

Updated 01/2023

Welcome to Fairfield Medical Center!

We are pleased to have you join our team!

Our responsibility to you is to ensure your safety and that of our patients and staff. Enclosed you will find all of the items needed for your successful onboarding to Fairfield Medical Center.

If you could complete the enclosed and return with all accompanying documentation, at least 2 weeks prior to your start at Fairfield Medical Center.

Again, welcome to Fairfield Medical Center! We look forward to meeting you and having the opportunity to build a personal and professional relationship with you!

Thank you and welcome!

Terri Hanna
Onboarding Specialist
Human Resources
740-687-8544
terriha@fmchealth.org

Fairfield Medical Center

Checklist for Students

Required Documents: All documents must be received at least two weeks before start of rotation.

- ❒ Completed application form; Employee demographic/contact information
- ❒ Affiliation Agreement with college/university
- ❒ Liability Waiver
- ❒ BCI Background check
- ❒ Copy of any License/Certifications (if applicable)
- ❒ 10 panel Drug Screen
- ❒ Two-step TB Test (or screening of positive reactors) within last 12 months
- ❒ Immunization history or titer
- ❒ Hepatitis B vaccine or documentation of declination
- ❒ Documentation of TDAP
- ❒ Current CPR certification (if working in patient care areas)
- ❒ Signed System Security Agreement
- ❒ Proof of current Flu Vaccine (if applicable)
- ❒ Post Test
- ❒ Documentation of COVID Vaccination

Onboarding Representative
Fairfield Medical Center
401 North Ewing Street
Lancaster, Ohio 43130

10 PANEL DRUG SCREEN

You will need to provide documentation of a negative 10 panel drug screen performed within the last 6 months.

TB TEST

You will be required to submit evidence of a current (2) **two step** negative TB Test. If you need to receive a TB test they may be obtained from your private physician or the health department

IMMUNIZATIONS

All students will need to provide proof that they are current on all immunization prior to beginning clinicals within FMC and/or its affiliate locations. Please include documentation of two (2) measles, mumps, and rubella (MMR) vaccinations, any Hepatitis B vaccinations, and flu and COVID vaccination or lab work indicating immunity to these diseases. If you are unable to provide up to date verification, you may go to your family physician or to the health department to receive these vaccinations.

FINGERPRINT/BACKGROUND CHECK

Background checks will be completed and turned in with your application. They need to be within 12 months of your application date. If you do not have a current background check, one may be obtained through:

Fairfield County Sherriff's Department
108 N. High Street
Lancaster, Ohio 43130
There is a fee for this service and payment is by cash or check only
NO debit or credit cards accepted.

ID BADGE

On your first day of clinicals with Fairfield Medical Center, you will need to report to the Human Resources department to get your picture taken and receive your name badge. Your ID badge is to be worn, facing forward at all times while here at FMC. There is a cost of $25.00 for any lost, damaged, or unreturned badge.

PARKING TAG

You will need to provide Fairfield Medical Center with your current vehicle information. You will receive a parking tag that will need to be displayed in your vehicle while at the Center.

General Information

TELEPHONE NUMBERS

Fairfield Medical Center Main line: 740-687-8000
Fairfield Medical Center Police: 740-687-8019
Human Resources Main Line: 740-687-8017

CAFETERIA

You are welcome to eat in the Center cafeteria. The cafeteria is open for lunch from 10:30 am until 1:30 pm and serves dinner from 4:30 pm until 6:30 pm.

LOST AND FOUND

Fairfield Medical Center is not responsible for lost articles. Articles found on the Center premises that are not Center property should be submitted to the Patient Representative. Should you lose personal articles on the Center premises, please contact a Patient Representative.

DRESS CODE

Please adhere to the uniform or dress code requirements for your particular discipline.

- Uniforms should be kept neat and clean.
- Recreational clothing, t-shirts, blue jeans, flip-flops, shorts, and leggings are not prohibited during clinicals at Fairfield Medical Center.
- Name badges are to be worn, forward facing, above the waist at all times while on duty. If lost, replacement badges will cost $25.00.
- Piercings are limited to 2 earrings per ear. All other piercings must be covered or removed.

PARKING

All students are required to park in the designated student parking lot. You will be issued a parking tag that will need to be displayed in your car during clincials at Fairfield Medical Center. Parking in the garage is not permitted.

PERSONAL PROPERTY

The Center is not responsible for lost or stolen articles. Please limit the amount of money and other valuables you bring to the Medical Center. Ensure that these items are either with you or properly secured at all times.

SMOKING

Effective July 1, 2006, Fairfield Medical Center became a smoke-free campus. You are not permitted to use tobacco products, of any kind, on the premise while here.

Fairfield Medical Center

Student Application

PERSONAL

Name _____ Phone # _____

Address_____ Cell # _____

City/State/Zip _____ Email _____

Social Security Number _____ Birthdate _____

Emergency Contact Name and Number_____

License plate Number_____ Car Make/Model_____

REQUEST

Number of Hours needed_____ Department_____

Have you made contact w/department?_____ Contact name_____

Dates requested_____

SCHOOL

School Name_____ Instructor_____

Instructor email_____

Instructor phone_____

Program of study_____

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 further access to Fairfield Medical Center (FMC) in my capacity as an employee of the above named physician and further disqualify me from consideration for employment. I hereby authorize my employer named in this application (resume, if any) to provide this facility with any relevant information regarding my abilities and work, and I release all such persons from any liability regarding the provision or use of such information. I acknowledge that I work for and under the direct supervision of the above name physician and that I am not an employee for FMC when working in that capacity.

Signature _____ Date _____

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

Fairfield Medical Center

SYSTEMS ACCESS SECURITY AGREEMENT

I, _____ have read, understood, and will comply with the following:
(Last name, First name, Middle initial)

____ 1. I understand that my system access is a function of my official duties and employment status:

a. System access is subject to annual renewal, and may be reviewed, modified, or revoked in the event that a system user's duties or employment status changes.
b. Accounts can be disabled or revoked at any time – with or without notification - in the interest of network security.
c. System access will be deactivated after 90 days of non-use, and accounts will be deleted with the termination of employment.
d. The Systems Department maintains an audit trail of accesses to patient information that records the user, date, and patient identification of all accesses to electronic medical records.
e. All information stored on Fairfield Medical Center devices is the property of Fairfield Medical Center.

____ 2. I am required to protect my accounts, passwords, system, and any information that I access:

a. I am absolutely liable for all activity that takes place under my credentials.
b. I am the only person authorized to use my password(s) and user ID(s) and I will not disclose them to anyone; nor will I attempt to learn or use another person's password(s)/user ID(s).
c. If I have reason to believe that the confidentiality of any password(s) or account(s) has been compromised I will contact the Systems Department immediately.

____ 3. I agree to maintain the confidentiality of any electronic patient data that I access or otherwise encounter:

a. I will access protected health information only for the purposes of facilitating treatment, payment, or other approved hospital operations (which may include educational or research purposes).
b. I am required to either log-out of the computer or lock the screen before leaving my system unattended.
c. I will immediately report any known or suspected breach of the confidentiality of the system or records/data obtained from it to the Medical Information Services manager.
d. I understand that medical records confidentiality is required by law, and that there are statutes specifically mandating the confidentiality of, among other areas, mental health, HIV, and drug and alcohol-related treatment records.

____ 4. I understand that I am restricted in what I am allowed to do as a system user:

a. I will not attempt to alter any security software, filters, policy, or configuration on any hospital devices.
b. I will not load, install, or remove any software on a hospital device or on the Common Desktop without assistance or approval from the FMC Systems Department. (Including screensavers and Internet toolbars).
c. I will not attempt to connect any unauthorized personal laptop, PC, or hand-held devices to unauthorized FMC wired or wireless networks.
d. I understand that if I do not accept these restrictions of access I may be denied access or have access terminated to relevant computer systems and networks.
e. I understand that any fraudulent application, breach of confidentiality, or other violation of the above provisions may result in disciplinary action ranging from termination of access to the system or appropriate disciplinary measures up to and including termination of employment by my employer.

Please initial all lines above and complete all information below:

Printed Name_____

Department/Unit: _____ Title/Position:_____ Date of Birth: _____

Telephone Number: _____ Fax Number:: _____ E-Mail Address: _____

Signature _____ **Date**_____

I. ADHERENCE TO FMC POLICIES AND PROCEDURES

I agree to abide by and adhere to the policies and procedures of Fairfield Medical Center. I have received instruction on key policies and procedures, information on accessing all policies and procedures and how to get clarification of any policy or procedure for which I have a question.

II. CONFIDENTIALITY STATEMENT/HIPAA

I understand that as a student at Fairfield Medical Center, I may come into contact with confidential information regarding patients and financial information produced by or held by Fairfield Medical Center. I shall not directly or indirectly, make or cause to be made, any disclosure or other use not authorized by Fairfield Medical Center of any confidential information unless such information is or becomes otherwise legally available to the public.

I have received, reviewed and had the opportunity to ask and have answered questions about the Fairfield Medical Center policies on confidentiality and HIPAA. I understand that I am required to adhere to such policies when dealing with any and all confidential information associated with Fairfield Medical Center.

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 Fairfield Medical Center and its patients, employees and physicians. Any breach of confidential information by me shall constitute grounds for any legal action taken by the offended parties. I also understand that my access to Fairfield Medical Center will be immediately terminated.

III. WAVIER OF LIABILITY/RELEASE WITH ASSUMPTION OF RISK AND INDEMNIFICATION

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

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

_____ _____

Student Date

Please send original copy to:
Fairfield Medical Center
Human Resources—Attention Onboarding Representative
401 N. Ewing Street
Lancaster, Ohio 43130

PARTICIPANT AGREEMENT OF LIABILITY AND INDEMNITY AGREEMENT

In consideration of executing this Participant Agreement of Liability and Indemnity Agreement **(this "Agreement") and participating in any way in the Fairfield Medical Center, an Ohio nonprofit corporation, or its affiliates or subsidiaries (collectively, "FMC") Job Shadow/Internship/Clinical [**NOTE: Choose the category that applies**] Program, now or at any time in the future (each participation an "Event" or "Events"), I, for myself, my personal representatives, heirs and next of kin agree to the following.**

PARTICIPANT REPRESENTATIONS AND WARRANTIES

I acknowledge and represent that: (1) I am at least 18 years of age; (2) I have informed myself about the Events; (3) I have agreed to participate in one or more Events after careful consideration of the risks that may be associated with the Events; (4) I understand that a hospital environment, even under the best of circumstances, may be unpredictable, and I may be exposed to disease, stress, patients having psychiatric emergencies, death, grief, traumatic injuries, and other unforeseen medical circumstances and I certify that I am in good health and that I have no conditions or impairments which would preclude my safe participation in the Event, including that I am current on all medical vaccinations, including but not limited to tetanus and all other recommended or required FMC vaccinations, or that I have made the decision to not vaccinate myself and understand the risks associated with that decision; (5) I warrant that I will agree to assume full financial responsibility for any and all damages to, or losses of, the real or personal property of FMC or any third party caused directly or indirectly, in whole or in party, whether or not foreseeable, by me, as determined by FMC in its sole and absolute discretion, and I further agree to indemnify and hold harmless the Released Parties from any third-party claims related thereto; (6) I warrant that I will participate in the Events only under the supervision of an FMC employee and understand that I am not an employee of FMC and will not receive any monetary compensation or benefits for participating in any Event; (7) I warrant that at all times during my participation in the Event, I shall comply with all policies and procedures of FMC; (8) I understand that I may come into contact with confidential information regarding patients and financial information produced by or held by FMC and I warrant that I shall not, directly or indirectly, make or cause to be made any disclosure or other use not authorized by FMC of any confidential information unless such information is or becomes otherwise legally available to the public; (9) I understand that my participation in any Events may be revoked or suspended at any time for non-compliance or safety issues, as may be determined by FMC in its sole discretion; and (10) I further recognize and agree that I am executing this Waiver and Release on behalf of myself.

ACKNOWLEDGEMENT OF RISK

I acknowledge that I fully understand my participation may involve risk of serious injury or death, including losses which may result not only from my own actions, inactions or negligence, but also from the actions, inactions, or negligence of others, the condition of the facilities, equipment, or areas where the Event or activity is being conducted. Such risks include but are in no way limited to slips, trips, and falls, and illness, including exposure to and infection with viruses or bacteria. I further acknowledge that the preceding list is not inclusive of all possible risks associated with participation and that said list in no way limits the operation of this Agreement. Such risks and

dangers may be caused by my own actions or inactions. I also acknowledge that any injuries I may sustain may be compounded or increased by negligent or delayed rescue operations or procedures of the Released Parties (as hereinafter defined). I further acknowledge there may be other risks and economic losses, which may be known to me or may be unforeseeable, that are presented by my participation in any Event held by FMC. I understand that if I have any risk concerns, I should discuss the risks associated with my participation with FMC before I sign this document and before any activity or Event begins.

CORONAVIRUS/COVID-19 WARNING & DISCLAIMER

Coronavirus, COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact. Federal and state authorities recommend social distancing as a means to prevent the spread of the virus. COVID-19 can lead to severe illness, personal injury, permanent disability, and death. Participating in an Event could increase the risk of contracting COVID-19. FMC in no way warrants that COVID-19 infection will not occur through participation in an Event or accessing FMC's facilities.

WAIVER, RELEASE, INDEMNIFICATION & COVENANT NOT TO SUE

I further agree to indemnify, save and hold harmless FMC, its affiliates, officers, directors, employees, volunteers, agents, representatives and insurers (the "Released Parties") from any and all claims, causes of action, demands, losses, damages and liabilities for indemnities, contribution or otherwise arising from my participation in an Event, including attorneys' fees related thereto, which I, my heirs, representatives, executors, administrators and assigns may have, now or in the future, with respect to any personal injury, property damage, death or accident of any kind, arising out of or in any way related to an Event, whether that participation is supervised or unsupervised, however the injury or damage occurs, including but not limited to the negligence of the Released Parties.

I acknowledge and agree that this Agreement is intended to be, and is, a complete release of any responsibility of the Released Parties for any and all personal injuries, temporary or permanent disability, death, and/or property damage sustained by me while on the property or in any way related to the Event activities and is intended to be as broad and inclusive as is permitted by the laws of the State of Ohio and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect.

EMERGENCY MEDICAL CARE

In the event that an alternative contact provided in writing to FMC cannot be reached in the event of an emergency, I authorize FMC and its representatives to act with respect to the provision of such care, and I consent for any and all treatment. I further agree to use my personal medical insurance as a primary medical coverage payment if accident or injury occurs and agree to pay all costs and expenses incurred in connection with any medical care provided, including the cost of transportation.

This Agreement will be governed by and interpreted in accordance with the laws of the State of Ohio. I agree that any action arising out of this an Event or this Agreement must be brought exclusively in any state or federal court located in Fairfield County, Ohio. If any provision of this Agreement is deemed invalid, void or unenforceable, such provision shall be considered severed

from this Agreement and the remaining provisions shall be given full force and effect. No change, modification, amendment, or addition of or to this Agreement shall be valid unless in writing and signed by the President of FMC. This Release shall be binding upon and inure to the benefit of the successors, assigns, and legal representatives of the parties.

I HAVE READ AND VOLUNTARILY SIGN THIS WAIVER AND RELEASE AND DO SO WITH THE UNDERSTANDING THAT SUBSTANTIAL RIGHTS ARE BEING GIVEN UP. I UNDERSTAND THAT MY PARTICIPATION IN THIS EVENT IS VOLUNTARY AND RELEASING THE RELEASED PARTIES IS PART OF THE CONSIDERATION FOR ME BEING ALLOWED TO PARTICIPATE. FOR THE AVOIDANCE OF DOUBT, THIS AGREEMENT SHALL COVER EACH EVENT I PARTICIPATE IN WITH FMC.

I HAVE READ THIS AGREEMENT

Signature

Print Name

Date