Holy Family Memorial Student Verification

Holy Family Memorial
Sponsored by the Franciscan Sisters of Christian Charity

Student Information

First Name: ______ Last: ______ Middle: ______

Home Address: ______ City: ______ State: ______ Zip: ______

Home Phone: ______ Cell: ______ Email: ______

Date of Birth: ______ Emergency Contact: (Name and Phone Number) ______

School Information

School: ______ Graduation Year: ______

Program Name: ______

Dates of Rotation: From: ______ To: ______ Number of hours required to complete: ______

Program Coordinator: ______ Email: ______ Phone: ______

This form <u>must</u> be accompanied by the following:
(If the information is on file at school, school coordinator can verify information by checking each item below.)

- ☐ Completed Wisconsin Caregiver Background Check law (Wisconsin Administrative code, Chapter HFS 12) including OIG/SAMS sanction check has been completed and the student is not barred from providing services under Chapter HFS 12. *Students with a criminal record are forwarded to Human Resources at Holy Family Memorial for review and approval prior to beginning the clinical training*
- ☐ Hepatitis B Series (dates) 1st ______ 2nd ______ 3rd ______ or a declination stating the student does not want the series.
- ☐ Proof of positive rubella immunity (1 or 2 vaccine dates) from Physician, Public Health Dept., or WIR.
- ☐ A TB skin test or TB Quantiferon Gold within the past year. Cannot decline.
- ☐ A tdap vaccine within the *last ten years.*
- ☐ History of chickenpox (varicella) with positive titer.
- ☐ Annual seasonal influenza (flu) vaccine (November-March)

Medical Student Only

- ☐ Current CPR card within the last 2 years
- ☐ Copy of current Wisconsin License to practice Medicine & Surgery (when applicable)
- ☐ Copy of DEA Registration (when applicable)

Signature of school authorized faculty: ______ Date ______

I agree to abide by the medical Staff By-laws, Rules & Regulations and hospital policies and procedures of Holy Family Memorial during my rotation.

Signature of student: ______ Date ______

Holy Family Memorial Medical Preceptors

I accept responsibility for all actions taken by the medical student and agree to direct, monitor and supervise all his/her activities during this rotation. I will advise my patients that this individual is a student and I will obtain the patient's written consent concerning any invasive procedure performed by this individual.

Signature of Supervising Physician: ______ Date: ______

Approval

VP Physician Services/Chief Medical Officer: ______ Date: ______

Return form including program objectives to:

Holy Family Memorial ♦ 2300 Western Ave. ♦ P.O. Box 1450 ♦ Manitowoc, WI 54221-1450
Treesa Peterik, = k o ♦ PH 920-320-4025 . FAX 920-320-5154 . tpeterik@hfmhealth.org

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Date: ___________________

Holy Family Memorial requires our student applicants to complete this form regarding possible TB symptoms. HFM needs to be certain that all employees/students are knowledgeable about the disease for your safety and our patient's health and safety. Please complete this form for our records.

Please review the symptoms below and check a "yes" or "no" in the appropriate box stating you do or do not have that symptom.

Symptom	Yes	No
1. Have you or anyone in your family ever had TB?		
2. Productive cough (3 weeks)		
3. Persistent weight loss without dieting		
4. Persistent low grade fever		
5. Night sweats		
6. Loss of appetite		
7. Swollen glands, usually in the neck		
8. Coughing up blood		
9. Shortness of breath		
10. Chest pain		
11. Had a Chest x-ray in the last 6 months? If yes, where?_____________________________		

Signature_____________________________

If further information or testing is required, you will be notified.
Thank you for your cooperation.

Human Resource Dept.
Treesa Peterik
P:920-320-4025
F: 920-320-5154
tpeterik@hfmhealth.org