

Experience.
Explore.
Discover.
Achieve.

Science

College of Science Medical Preceptorship:

Information Packet
& Application

Medical Preceptorship Information Sheet

(please keep this information for future reference)

The medical preceptorship program is designed for pre-medical students interested in gaining valuable experience in the medical field. The preceptorship is a one credit class where students are expected to shadow a physician for a minimum of 27 hours during the term. Students are matched with community physicians based on availability in local hospitals, clinics and physicians' offices. Students attain the opportunity to observe medical procedures; physicians' interactions with patients and family members; and physicians' work load and administrative functions. In addition, students have the opportunity to ask pertinent questions.

To be accepted into the program, students **must** be enrolled at OSU, have no previous participation in the program, be of **junior/senior** standing with at least a 3.3 GPA, apply by the deadline, and complete an interview. Students are also required to provide **updated documentation** of immunization.

Prior to beginning the preceptorship program, students are required to attend a mandatory course orientation where course expectations communicated, a syllabus distributed and questions answered. In addition, and depending on placement, students might be required to attend an orientation by the organization of which they will be placed with. During such session each student will receive training in HIPPA as well as infection control, and sexual harassment.

Upon completion of the application (please type or write **legibly**), to include proof of immunization, turn it in to Ms. Ariella Wolf in 128 Kidder Hall. Please contact Ms. Wolf at (541) 737-4811, or ariella.wolf@oregonstate.edu if you have any questions.

The following is a list of what is expected of you while participating in the program:

- You will be expected to shadow your physician for 27 hours during the term. It is up to you and the physician's office to set a schedule that accommodates both of you. You will observe office visits and procedures, and have the opportunity to ask questions and learn about the daily activities of a physician.
- You are expected to submit a **reflective** journal of your experience, which will be explained in detail at course orientation. Late submissions will not be accepted. Journal Guidelines and examples can be found on the College of Science web site:
http://www.science.oregonstate.edu/system/files/Journal_Guidelines9_24_07.pdf
- Depending on your placement location, you may be required to undergo a background (BG) check and/or drug test. **The cost of these tests will be your responsibility.** Please send your BG payment to organization ASAP.
- Most likely, you will be required to wear a lab coat. If you do not already have one, you may purchase one at the bookstore (~ \$ 20) or at any uniform store. **If you are required to wear a lab coat and do not have one when you go to your preceptorship, you may be sent home.**
- You will be provided with a name tag; please wear it to identify yourself as a student to staff and patients. **If you do not have your name tag when you go to your preceptorship, you may be sent home.**
- If you are sent home **twice** for not complying with the rules of your facility you will be dropped from the program, will not be allowed to finish your preceptorship, will not be allowed to participate in the future, **and will receive a grade of No-Pass.**
- **Further elaboration of the above expectations to be discussed at orientation. You are expected to know and follow all rules of the facility you are placed with.**

Medical Preceptorship Checklist

(please keep this information for future reference)

- _____ Complete the application form, including your areas of interest. If a particular physician has agreed to work with you, you may indicate it on the form (page 3). Please be aware that the organization the physician is working for might seek reaffirmation of physician's commitment.
- _____ Include a photo of yourself with your application, no bigger than 3x3.
- _____ **IMPORTANT:** Complete the enclosed Health Forms (page 4) and arrange for any needed immunizations from OSU Student Health Services or from your family physician (cost is about \$15 for TB, \$40 per dose of 3 Hepatitis B shots, \$50 for Tdap, and \$60 for Varicella). **You MUST include documentation of all required immunizations with your application.**
- _____ Turn in a **complete** packet to 128 Kidder Hall by deadline. At this time you may schedule an interview time with Ms. Ariella Wolf, or you may call (541) 737-4811 to schedule the interview. *Please do not email for interview times.*
- _____ Orientations: course and organization orientations are **mandatory**. Depending on your placement, the duration, components, requirements, and format of the orientation might vary for each student. Further information will be given at orientation.
- _____ Background check: Depending on placement, send your payment for background check (~ \$50) immediately when notified to do so. Any delays on your part will delay the start of your preceptorship.
- _____ Drug test: Please arrange to undergo a drug test immediately when notified to do so. **DO NOT** undergo the test before you have been instructed or it will not be valid and you may need to repeat the test again, at extra cost to you. **DO NOT** substitute with acquired artificial urine as it will be detected right away and will disqualify you from the program.
- _____ *When instructed*, sign up for 1 credit of GS 410-002 (CRN is in the online catalog). Please note that occasionally your overrides for the class will be given to you only a few days before the term begins or after classes have started.
- _____ Submit your reflective journal throughout the term as instructed in the Journal Guidelines.
- _____ When your time with your physician comes to an end, have them complete the evaluation and send a thank you note to him/her and the office.

For deadline information please see the Preceptorship web site at:

<http://www.science.oregonstate.edu/node/129>

Application to Participate in the Medical Preceptorship Program

(Must have Junior or Senior standing, at least a 3.3 GPA, and no prior participation in the program)

Name _____ Class Standing: Junior / Senior GPA _____

ID # _____ Email _____

Telephone No. _____ Alternate Phone _____

College _____ Major _____ Expected Graduation Date _____

Term Applying for _____ Can you drive to Albany or Lebanon if necessary? Y/N
(please circle location)

AREA OF INTEREST: Please rank your top three choices in order of preference.

(Depending on physicians' availability, it may not be possible to match you with your preferred specialty.)

- | | |
|-----------------------------|--|
| _____ Emergency Medicine | _____ Pediatrics |
| _____ Family Practice | _____ Psychiatry |
| _____ Orthopedics | _____ Osteopathic Physician (D.O.) |
| _____ Internal Medicine | _____ I have already spoken to a physician who |
| _____ Gastroenterology | has agreed to have me shadow him/her; |
| _____ Renal Medicine | Physician's name _____ |
| _____ Obstetrics/Gynecology | (Additional approval might be necessary) |

Previous clinical experience (if existing):

What do you hope to gain from this program?



Samaritan Health Services

Student Health Testing

TB Screening

If you have no record of a Tuberculin Skin Test (TST) within the past 12 months, you will need to have one placed and read at Samaritan Occupational Medicine (SOM) or the facility of your choice. If you had a **positive** TB skin test in the past, you will need to complete a TB Risk Factor Screening form and chest x-ray or provide the Manager of Student Services with a record of a chest x-ray report dated within the last 6 months.

We require the following vaccines for regulatory compliance and/or to ensure immunity status, which is an essential part of our disease and infection prevention programs. Vaccinations may be obtained from Samaritan Occupational Medicine (SOM) or a facility of your choice. The expense of the immunization(s) is the responsibility of the student. If you decide not to receive the required vaccines, you may not be able to be placed within the hospital.

Measles (Rubeola), Mumps & Rubella

Please provide one of following as evidence of MMR immunity:

- a. Two MMR vaccines, **OR**
- b. Two Measles (Rubeola), two Mumps and one Rubella vaccine, **OR**
- c. Laboratory evidence of Rubeola, Mumps and Rubella immunity, **OR**
- d. Physician documentation of disease

Varicella (Chicken Pox)

Please provide one of the following as evidence of Varicella immunity:

- a. Two doses of age-appropriate vaccination with a Varicella vaccine, **OR**
- b. Serological evidence of Varicella immunity, **OR**
- c. Physician documentation of disease, **OR**
- d. Physician documentation of Herpes Zoster

Tdap (Pertussis Vaccine)

A single dose of Tetanus, Diphtheria and Acellular Pertussis (Tdap) vaccine will be required for volunteers who have direct patient contact and are less than 65 years of age.

Hepatitis B

If student activities include possible exposure to blood or other infectious material, they may be at risk for acquiring Hepatitis B (HBV). It is strongly recommended that students who have the potential to be exposed to blood or other infectious material be vaccinated against HBV.

Definition of Health Care Personnel (HCP), March 2008

HCP refers to all paid *and* **unpaid** persons working in health-care settings who have the potential for exposure to patients and/or to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air.

HCP might include (but are not limited to) physicians, nurses.....and students not directly involved in patient care but potentially exposed to infectious agents that can be transmitted to and from HCP and patients. These recommendations apply to HCP in acute care hospitals, nursing homes, skilled nursing facilities, physician's offices, urgent care centers, and outpatient clinics, and to persons who provide home health care and emergency medical services.

Direct Patient Contact Definition

An employee (student, volunteer) who provides hands-on patient care (e.g. nurse, doctor, physical therapist, respiratory therapist, etc.) or hands-on patient services (e.g. radiology technician, radiation therapist, phlebotomist, etc.).



Samaritan Health Services Non-Employee Medical Information Form



Name (Print): _____ Phone # _____ Email: _____

It is the responsibility of the student to have these immunizations completed prior to first day of their rotation. Documentation (immunization card or physician records) or serologic proof of immunity is required for all tests and immunizations.

MMR: _____ (Date) 2nd MMR: _____ (Date)

OR

Rubella Titer: _____ + or - _____ (Date) Rubeola Titer: _____ + or - _____ (Date) Mumps Titer: _____ + or - _____ (Date)

Hepatitis B Vaccine

1st Dose: _____ Institution: _____

2nd Dose: _____ Titer Date: _____ Result: _____

3rd Dose: _____

I have read the student HBV Immunization guidelines and choose not to have the vaccine: _____ (Signature)

Varicella Dates of vaccine: #1 _____ **OR** **Varicella** Titer _____ + or - _____ (Date)
#2 _____

OR Physician documented disease or physician documented herpes zoster.

Tetanus, Diphtheria, and Pertussis

Tdap _____ (Date)

TB Skin Test Date: _____ mm/Induration _____ **Must be within last 12 months.**

Have you ever had a positive TB test? Y/N _____

- If yes, please complete TB Risk Factor Screening form.
- If yes, please attach last chest x-ray report. _____
- Have you ever completed preventative drug therapy (INH)? If yes, in what year? _____

I attest the information provided is true, complete, and accurate to the best of my knowledge:

(Signature of student) (Signature of parent if student is under 18) (Date)

(Signature of SHS representative) (Title/Dept) (Date)

Please Return to:
Skip Panter
Office of Medical Education
3600 NW Samaritan Drive
Corvallis, OR 97330



TB RISK FACTOR SCREENING



To be completed **only** if you have a history of a **positive** Tuberculin Skin Test

NAME: _____ **DATE:** _____

Please answer yes (y) or no (n) to the following questions:

1. Have you ever had a positive TB test? _____ If yes, what year? _____
2. Have you ever been diagnosed with TB? _____ If yes, what year? _____
3. Have you previously completed preventative therapy (INH) or treatment for tuberculosis? _____ If yes, what year? _____
4. In the past year have you had:
 - A. Close exposure to someone with TB _____
 - B. Chest x-ray consistent with tuberculosis that was untreated _____
 - C. A problem with substance abuse _____
 - D. Diabetes mellitus (Severe or poorly controlled) _____
 - E. HIV infection _____
 - F. Immuno-suppressive therapy i.e., steroids _____
 - G. Any symptoms of pulmonary TB, such as productive, prolonged cough; chest pain; and/or hemoptysis (bloody sputum) _____
 - H. Any of the following conditions that will increase your risk of TB disease (circle all that apply):

<ul style="list-style-type: none"> - Hematologic & reticuloendothelial diseases (e.g. Leukemia, Hodgkin's disease) - Cancer of the head/neck - Silicosis - Chronic malabsorption syndromes 	<ul style="list-style-type: none"> - Intestinal bypass/gastrectomy - End stage renal disease - Low body weight - None of the above
--	---
 - I. Any systemic symptoms of TB, such as (circle all that you experienced):
 Fever/Chills Night Sweats Easy Fatigability Loss of Appetite Weight Loss

None of the above

Signature

Date

Explanation to any "Yes statements and other comments:



Samaritan Health Services



Pertussis Declination Form

I understand that due to my clinical placement I may be at risk of exposure to Pertussis also known as Whooping Cough. I have been advised to be vaccinated with the Tetanus, diphtheria, acellular pertussis (Tdap), however I decline the vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Pertussis, a serious disease, and may also expose others to the disease if I become ill.

I understand that non-immune students who refuse to be vaccinated cannot work in areas where the patient population may include children less than one year of age, near term pregnant women and/or postpartum women.

Non-immune students are required to report any possible exposure to pertussis to the Infection Control Nurse immediately. Non-immune students who are exposed to pertussis may be excluded from their clinical placement for the duration recommended by the Centers for Disease Control.

I have read the above information and understand that I may be excluded from my clinical placement for a designated length of time if I am exposed to pertussis. I also understand that I am required to report any possible exposures to the Infection Control Nurse as soon as I am aware of being exposed to pertussis.

Signature: _____ Date: _____

Name (Print): _____

School (Print): **Oregon State University**

Dates of Rotation: _____
(Beginning & Ending Dates)

Location of Rotation: _____

Witness Signature: _____
(Must be Hospital Employee)

Title/Dept: _____

Comments: If unable to take the vaccine due to medical reasons, please explain.



Samaritan Health Services Student Criminal Records Check Consent/Authorization



In order to serve the best interest of the patients of Samaritan Health Services (SHS), we deem it necessary to conduct criminal record checks on student/intern candidates. The following request for information must be completed by you, the student/intern, and returned to the SHS Coordinator of Student Experiences before an internship can be authorized. Your signature on this form authorizes SHS to obtain information from any law enforcement agency, court and/or record source, or consumer reporting agency, and investigate any matter relevant to the evaluation of your suitability for training with Samaritan Health Services.

Any falsification, misinterpretation, or omission of required information will result in denial of placement in an internship or training position, or immediate termination, regardless of when and how discovered. Disclosure of a criminal history/conviction does not necessarily disqualify a student from acceptance into SHS training/internship programs.

This consent form does not apply to criminal records expunged (obliterated) pursuant to ORS 419.262. Information obtained by a criminal records check will be used for job-related purposes only, to the extent permitted by the applicable law. Criminal background checks conducted using consumer reporting agencies are governed by the federal Fair Credit Reporting Act—please read “Summary of Your Rights Under the Fair Credit Reporting Act”

at: <http://www.samhealth.org/SiteCollectionDocuments/Education/College/StuFCRAFacts.pdf> and keep it for your reference.

Full Name (include ALL names used, past and present, including middle name & maiden/former surnames)		
Date of Birth	Social Security Number - -	Driver’s License Number and State
List states, outside of the state of Oregon, where you have lived in the past 10 years		
Have you ever been convicted of a felony or misdemeanor? Y / N if yes, list charge(s)/state(s) in which charged.		
<i>Use back of form for additional explanation if necessary</i>		

I have read and understand this request for information and the attached Summary of Rights under the Fair Credit Reporting Act and agree to hold Samaritan Health Services, its officers, agents, and employees harmless from any liability resulting from the use of the information requested.

Student/Intern Signature _____ Date _____

For Student Internship with SHS

Facility/Entity _____

CIS Check Date
By

(For HR use)

Record Found: Yes No
Approved: Yes No



Student Criminal Records Check Request

STUDENT INFORMATION

Student Name: _____

Phone Number: _____

Current Mailing Address: _____

To be completed by Professional Development

Student/Internship Type: _____

ID Verified
(List ID Type and Number): _____

Fee Paid

Please attach a copy of the completed Criminal Records Check Consent Form.

To:	SAGH Human Resources	Date:	_____	Time:	_____
Fax:	82-4610				
From:	SHS Professional Development Coordinator of Student Experiences				
Fax:	80-6058				

Return Correspondence

To:	SHS Professional Development – Coordinator of Student Experiences				
Fax:	80-6058				
From:	SAGH Human Resources	Date:	_____	Time:	_____

Comments:

CONFIDENTIALITY NOTICE:

This facsimile transmission may contain confidential and privileged information. The information contained in this transmission is intended for the addressee only. If you are not the addressee of this facsimile, please do not review, disclose, copy, or distribute it. If you have received this transmission by mistake, please telephone SAGH Human Resources immediately: ph. 541-812-4107. Thank you.



OREGON STATE UNIVERSITY
Office of Student Conduct
327 Snell Hall – 541.737.3656
RELEASE OF INFORMATION

Name: _____

Student ID number: _____

I give my permission to:

Dan Schwab, Program Coordinator, Office of Student Conduct
or designee: **Resa Cochran**
Oregon State University
327 Snell Hall
Corvallis, OR 97331-8515
541-737-3658

to disclose information from my confidential student records.

This information will only be disclosed to (name/s, title/s):

Ariella Wolf, Chief Pre-physical therapy / Pre-optometry / Pre-physician assistant
Advisor, College of Science, OSU

Description of information to be disclosed:

My conduct at OSU
My academic standing at OSU

for the purpose of: applying to the preceptorship program at OSU.

Permission to release this information shall expire on:

(enter date 2 months from today's date) _____
(date)

Student signature (date)