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SHERIDAN MEMORIAL HOSPITAL

SMH Personnel Form: Students

DEMOGRAPHICS		
Name:	**DOB:**	
Mailing Address:		
City:	**State:**	**Zip:**
Email Address:	**Phone:**	

EDUCATION

Medical Student Year: _____

PA or NP Student Year: _____

Health Science Student (Nursing, MLT, Radiography, etc.)

Job Shadow/ High School Student (Observer)

School/Organization (if applicable):	Specialty (if applicable):
Program Director/ Instructor:	Phone Number:

EMERGENCY CONTACT	
Emergency Contact: (Name, Relationship)	Phone Number:
Emergency Contact: (Name, Relationship)	Phone Number:

Dates onsite at SMH_____to _____

CONFIDENTIALITY AGREEMENT and PRECEPTEE POLICY

I, (Print Name)_____do hereby agree that I will:

1. Protect the confidentiality of patient and hospital information.
2. Not divulge/share unauthorized information to any source.
3. Not access or attempt to access information other than that information which I have authorized access to, and a need to know, in order to complete my assigned tasks.
4. Report breaches of this confidentiality agreement by others to Sheridan Memorial Hospital's Compliance Officer. I understand that failure to report breaches is an ethical violation which may subject me to disciplinary action up to and including termination.

_____ _____

SIGNATURE DATE

I have read and agree to adhere to the conditions of the Medical Staff Preceptee Policy, outlining the roles, responsibilities and patient care activities. I also acknowledge that any violation of the above conditions can result in disciplinary action up to and including termination.

_____ _____

SIGNATURE DATE