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Our Lady of Lourdes

Regional Medical Center

Institutions requesting approval for clinical rotation are required to provide documentation of the information listed below as a mandated by OSHA, CDC, TJC, and hospital policy. By dating and signing below, the Institution is attesting that the students and faculty submitted have completed and have on file those aforementioned items. The Institution is also attesting that all information will be current through the ending date of the clinical rotation as designated on this document. The institution shall maintain these documents for three (3) years. If a regulatory body request such documents upon audit at any campus at Our Lady of Lourdes Regional Medical Center, the institution must provide the document(s) upon request.

* Background check
  + Social Security verification
  + Criminal Search
  + Violent Sexual Offender and Predator Search
  + OIG List of Excluded Individuals/Entities
  + GSA List of names excluded from Federal Programs
  + US Treasury, Office of Foreign Assets Control (OFAC), List of Specially Designated Nationals (SDN)
  + Professional Disciplinary Action Search
* All applicable board approval for participation in clinical program
* Satisfactory 10 Panel Drug Screen
* Medical Clearance for Participation in a clinical program
  + Screening for immunity to infectious/communicable disease to include at a minimum Hepatitis B, Varicella, MMR and TDAP.
* PPD or Chest X-Ray
* Flu Vaccination Compliance October 1-March 31
* COVID Vaccine Compliance (2 doses of Pfizer/Moderna or 1 dose of J&J) or School approved exemption on file
* BLS Healthcare Provider Certification

Institution’s Faculty/Coordinator Signature Date

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**Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Rotation Campus: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Rotation start date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Clinical Rotation end date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Instructor Information (if applicable): Type in the information and return electronically**

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| **Last Name** | **First Name** | **Last 4 SS #** | **COVID vaccine (Yes/No/Exempt)** | **Flu vaccine (Yes/No/Exempt)** |
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**Student Information: Type in the information and return electronically**

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| --- | --- | --- | --- | --- |
| **Last Name** | **First Name** | **Last 4 SS #** | **COVID vaccine (Yes/No/Exempt)** | **Flu vaccine (Yes/No/Exempt)** |
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