Salina Family Healthcare Center
A Federally Qualified Community Health Center
651 E. Prescott, Salina, KS 67401
Medical Center ~ (785) 825-7251
Dental Center ~ (785) 826-9017
Pharmacy ~ (785) 452-3900

Student Application Packet

Dear Student,

Thank you for interest in completing your school-based practical experience at Salina Family Healthcare Center clinical team. Prior to beginning your service with Salina Family Healthcare Center you must complete the enclosed application and be approved by our Board of Directors. The application process involves evaluating the existence of necessary documentation and finding a mentor/preceptor who is employed by Salina Family Healthcare Center that is willing serve as your mentor/preceptor. Our policy applies to students who will provide clinical services and administrative tasks at Salina Family Healthcare Center. All qualified applicants will receive an application for medical staff membership and/or clinical privileges. We will make every effort to process your application in a timely and efficient manner.

Application is a five-step process:
Step 1: Applicant will receive the initial applicant packet.
Step 2: Applicant will return completed applications along with requested documents.
Step 3: Application will be reviewed and processed by our Director of Human Resources and Compliance to make sure all information is complete and accurate.
Step 4: The completed and verified applicant packet will be presented to the Board of Directors for approval.
Step 5: The Applicant will be notified of the Board of Directors' decision.

The credentialing process can take up to 60 to 90 days to verify, review, and obtain final approval. To expedite the process, your application should be completed without blanks or missing requested documents. If anything is missing, the process will be delayed.

If at any time you have questions, please contact me at (785) 825-7251 or set up a meeting to come to Salina Family Healthcare Center and go over your application prior to submission. Our goal is to assist you to complete the process quickly while ensuring that we are compliant with relevant guidelines we must follow.

Sincerely,

Audrey Lee
Director of Compliance and Risk Management

STUDENT APPLICATION

Please type or print responses legibly and in ink. Please complete the form in its entirety and attach all required documentation. Incomplete applications will be returned to you and may result in a delay in process.

Documents that must be completed and submitted include the following:

- Completed student application.
- Copy of most recent flu and hepatitis B vaccination, tuberculosis PPD test, and immunization record.
- Signed Student Professional Conduct Standards.
- Signed Confidentiality Statement.

Please verify that the following documents are on file with Salina Family Healthcare Center:

- Verification of collaborative agreement, if applicable, with training institution including:
    - Statement of affiliation with the training institution,
    - Statement that the training institution's liability insurance will be responsible for any acts of professional negligence, and
    - A release and hold harmless agreement.
- Copy of private liability coverage extended from the training institution.
- Copy of medical malpractice insurance coverage, if applicable.
- Documentation of the training institution's expectations of the student and the clinic during the student's placement at the clinic.

I. Personal Information (please print)

Student Name: _____

Address/City/State/Zip: _____

Phone: _____ Email: _____

Gender: ☐ Male ☐ Female

Emergency Contact: _____ Relationship: _____

Phone: _____Email: _____

II. Request for practical experience

Will you be ☐ providing clinical services or ☐ providing administrative services?

Dates requested: _____

What activities will you be performing under the supervision of your mentor/preceptor? _____

_____

_____

Is this observation related to a school/college course? ☐ Yes ☐ No

If yes, please provide: The course name: _____

School: _____

Instructor: _____

III. Request for practical experience

The responsibility for the student's involvement and activities in both clinical and administrative activities at Salina Family Healthcare Center will be under the supervision, direction, and control of their mentor or preceptor.

Mentor/Preceptor Printed Name: _____

Mentor/Preceptor Signature: _____

Student Signature: _____ Date: _____

Immunization Verification Record

Name: _____ **Work Area:** _____

Instructions: Students observers will provide documentations showing compliance with immunization and tuberculosis screening requirements. Check the appropriate box. An official record of immunizations or laboratory results from a health care provider is required for verification.

MMR (measles, mumps, rubella): Proof of immunity must be met by one of the following.

☐ Adequate Immunization	**Measles**	Date 1: _____	Date 2: _____
	Mumps	Date 1: _____	Date 2: _____
	Rubella	Date 1: _____	Date 2: _____
☐ Documentation of disease	**Measles**	Date: _____	
	Mumps	Date: _____	
	Rubella	Date: _____	
☐ Immune titer, if done	**Measles**	Positive Negative	Date: _____
Attach copy of result (required)	**Mumps**	Positive Negative	Date: _____
	Rubella	Positive Negative	Date: _____

Chickenpox: Documentation of immunity must be met by one of the following.

☐ Documentation of chickenpox Date: _____

☐ Adequate Immunization – Varicella Date 1: _____ Date 2: _____

☐ Varicella titer Date: _____ Results: _____

☐ Uncertain: Positive verification from relative: _____ Relationship: _____

☐ Has not had chickenpox. The individual cannot have contact with patients with shingles or chickenpox. If exposure to chickenpox occurs the individual must be excluded from the facility from day 10-21 following exposure. If an individual develops chickenpox, they will be excluded from the facility until all lesions are crusted over and there are no new lesions.

Tuberculosis Test: A tuberculin skin test is required within the last 12 months.
Date: _____ Results: _____

Hepatitis B

☐ Vaccine Series Date 1: _____
Date 2: _____
Date 3: _____

☐ Immune Titer Positive Negative Date: _____
Attach copy of result (required)

Verification by a health care professional is required:

Verified by: _____ Date: _____

School/Agency: _____

Statement of Confidentiality

I (print name) _____ understand that while visiting and/or participating in special education projects, clinical experiences and other activities at Salina Family Healthcare Center, I may have access to information which is of a confidential nature. Because the learning activities are educationally beneficial, I am expected to respond at all times in a professional manner. Any information, either written or oral, having any relevance to patient care is strictly confidential. Discussions regarding patients and/or any Salina Family Healthcare business information are restricted to the proper professional environment under the supervision of appropriate personnel.

It is understood, that violation of that confidentiality, whether intentional or involuntary, may result in disciplinary action, up to and including termination from the practical experience at Salina Family Healthcare Center, and may result in civil and/or criminal liability.

By my signature, I verify that I have read the above information and agree to abide by Salina Family Healthcare Center's policies pertaining to HIPAA, patient confidentiality, and the confidentiality of business records.

_____ _____

Student Signature Date

_____ _____

SFHC Personnel Signature Date

Student Professional Conduct Standards

1. It is the student's duty to obtain and maintain current certifications required for their assigned activities.
2. It is the student's responsibility to collect and submit documentation necessary for their education program.
3. The student must comply with SHEF Code of Conduct.
4. The student must comply with all documentation requirements for their assigned department.
5. The student will respond to patient messages and complete patient notes in an appropriate time as determined by Salina Family Healthcare Center Policy.
6. The student will seek feedback from their SFHC mentor/preceptor to promote ongoing self-improvement.
7. The student will arrive to scheduled shifts on-time.
8. Patient care in all settings will be patient-centered and family-centered.
9. Students must develop habits of conduct that are perceived by patients and peers as signs of trust. Every student must demonstrate sensitivity, compassion, integrity, respect, professionalism, and maintain patient confidentiality and privacy. A patient's dignity and respect must always be maintained. Under all circumstances, response to patient needs shall supersede self-interest.
10. Unaltered ID badges must be worn and remain visible at all times by the student.
11. If the student is not wearing scrubs, the student must wear clothing that reflects a professional image. No shorts are permitted.

    Men: Dress-type pants and collared shirt. Facial hair must be neat, clean and well-trimmed.

    Women: Skirts and dresses must be at or below the knee. Clothing should cover back, shoulders, midriffs - modest neckline (no cleavage).

I have read this Professional Conduct Standards of Students and do hereby demonstrate my understanding and agreement to abide by these guidelines by affixing my signature and the date below.

_____ _____

Student Signature Date

BOARD APPROVAL

Name of Student: _____

Area of Specialty: _____

Each request for a student practical experience will be considered on an individual basis and will require approval and supportive documentation. The above named individual certifies that s/he is competent to complete the duties requested for the practical program.

Course name: _____ School: _____

Instructor: _____ SFHC Mentor/Preceptor Name: _____

What activities will you perform under the supervision of your mentor/preceptor? _____

_____

_____

_____

By signing below Student attests and acknowledges:

- That that they have received adequate training, instruction, and experience for the above requested activities.
- Any restriction on clinical activities is waived in an emergency situation.
- Clinical privileges expire at the end of the student's program.

_____ _____

Student Signature Date

Submitted for approval by:

_____ _____

Director of Compliance and Risk Management Date

Temporary approval is granted until the next meeting of the SHEF Board of Directors by:

_____ _____

SHEF Executive Name Date

The Board of Directors of Salina Health Education Foundation (SHEF) dba. Salina Family Healthcare Center (SFHC) hereby approves credentials of the above named individual and approves them for placement under the auspices of SHEF dba. SFHC within the scope of the student's educational program for the duration of the program.

Approved on behalf of the Board of Directors by:

_____ _____

Board President (or designee) Date