Medical Student Application

Date: ____________________

Full name: ____ ________________
Rotation Year

Home address: ____
City State Zip

Date of Birth: _________________________ Social Security Number: ________________________________

Cell Phone: ____________________ E-mail: ____

Name of Rotation: Community: ____________ Elective: ___________ Other: _____________________

Date of rotation: Starting Date: _______________________ Ending Date: ______________________

DISCLOSURE INFORMATION

1. Has your employment at a health care organization ever been terminated? Yes_____ No_____
2. Have you ever been charged or convicted of a crime other than a minor traffic offense? Yes_____ No_____
3. Are there any felony charges pending against you? Yes_____ No_____

You have the right to elect not to answer these questions if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution.

____ ______________________________________
Signature Date

Completed application must be received no later than two (2) weeks prior to rotation. Fax or mail to Janie Rodriguez, Residency Program Coordinator, Northeastern Health System, P.O. Box 1008, Tahlequah, OK 74465-1008. Phone (918)-458-2406, Fax (918)-458-2486, E-mail jerodriguez@nhs-ok.org

****Documentation required Copy of: Immunizations, School's liability insurance, and Photo ID ****

Private, Confidential and Privileged pursuant to 63.O.S. Section 1 –1709 A(2), A(5), A(6); B(1)

HEALTH STATUS

This information is necessary to determine if you have a physical or mental condition which could affect your ability to exercise the clinical privileges requested and/or what accommodations are necessary and /or reasonable to allow you to practice safely and completely.

____

Print Name

Present health status: _____ Good _____Fair _____Poor

A. Have you been hospitalized any time during the past five years? _____Yes _____ No

B. Have you ever been denied health, life or disability insurance? _____Yes _____ No

C. Do you have any limitations on your health, life or disability insurance? _____Yes _____ No

D. Have you ever had any problems with alcohol or drug dependency? _____Yes _____ No

E. Are you currently taking any medication that may affect either your clinical judgement or motor skills? _____Yes _____No

F. Are you currently under any limitations, concerning your activities or workload? _____Yes _____ No

G. Are you currently under the care of a physician? _____Yes _____ No

I. Last TB test: __________________________ Negative____ Positive _____
Date

If you have answered yes to any of the above questions, please give a full explanation of the details on a separate sheet, and attach.

Additional information may be requested.

_____________________________ _____________________________
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CONFIDENTIALITY ACKNOWLEDGEMENT

Through my association with Northeastern Health System, as an employee, agent, volunteer, student, or approved observer, I understand that patient information in any form (paper, electronic, oral, etc.) is protected by law and that breaches of patient confidentiality can have severe ramifications up to and including termination of my relationship with Northeastern Health System as well as possible civil and criminal penalties. I will only access, use or disclose the minimum amount of patient information that I am authorized to access, use or disclose and that is necessary to carry out my assigned duties. I will not improperly divulge any information, which comes to me through the carrying out of my assigned duties, program assignment or observation.

This includes but is not limited to:

- ❖ I will not discuss or disclose information pertaining to any patient with anyone (even my own family) who is not directly working with said patient.
- ❖ I will not discuss any patient information in any place where it can be overheard by anyone who is not authorized to have this information.
- ❖ I will not mention any patient's name or disclose directly or indirectly that any person is a patient except to those authorized to have this information.
- ❖ I will not describe any behavior, which I have observed or learned about through association with this Hospital, except to those authorized to have this information.
- ❖ I will not contact any individual or agency outside this Hospital to get personal information about an individual patient unless a release of information has been signed by the patient or by someone who has been legally authorized by the patient to release information.
- ❖ I will not use confidential Northeastern Health System business related information in any manner not required by my job or disclose it to anyone not authorized to have or know it.
- ❖ The responsibilities of my job may place me in a position to access confidential information regarding physicians, employees and others. I will respect this information and not discuss in any manner with patients, physicians, other employees or those outside the hospital.

With my signature, I indicate I have read and understand this Acknowledgement. Further, I understand that intentional or involuntary violation of this Confidentiality Acknowledgement is basis for disciplinary action, up to and including termination.

______________________________	______________________________
Signature	Date of Signature
______________________________	______________________________
Printed Name	Social Security #

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