CULLMAN REGIONAL

Statement of Comprehension
Clinical/Non-employee-(will have patient contact)

Affiliation: College (i.e. WSCC): _____

School upon request is responsible for forwarding verification of students: vaccines, background checks, health and liability insurance, and current CPR card that will not expire during clinical rotation.

Department Rotation Site (Please check as appropriate)

DI-Radiology		*Respiratory*		*Lab-Phlebotomy / Techs*			*EMS (ALL)*		
DI-Ultrasound		*Speech Pathology*		*Home Health/Hospice*			*Case Management*		
DI-Nuclear Med		*Surgery / CRNA*		*One Fitness*			*Cardiovascular*		
One Rehab- OT - OTA		*Neuro-EEG*		*Scrub Techs*			*Mammography*		
One Rehab- PT - PTA		*Sleep Center*		*Central Sterile Tech*					
Endo / Pain Center /MDH		*PACU*		*ODS*					
Pharmacy- Techs / Pharmacist		*CPAP*		*Social Services*			**Rotation Date**		
Other:_____		*CNA*		*Nutritional Therapy*			**Beginning___/___/___**		
Clinical Nursing ALL Areas		*CCU*		*4 East*	*3 West*		**Ending_____/___/___**		
		Emergency Room		*5 East*	*3 East*				

Confidentiality is a basic element of the operation of Cullman Regional Medical Center. Release or use of any employee, patient/customer/resident, or other company information is a violation of this policy including release or use for personal benefit.

The care and treatment of customers/patients are highly personal in nature. Therefore, all information concerning patients' medical or personal matters will be kept strictly confidential. This information will be discussed only with the patients attending physicians and the authorized personnel directly responsible for the patient's care and treatment. Care will be exercised to be certain that authorized individuals do not overhear any discussion of confidential information. All individuals allowed in the patient care areas have a legal obligation to ensure that patient's medical information is held in strict confidence and only discussed with those persons involved with the care of that patient.

I understand that I am responsible for strict compliance with all privacy and confidentiality requirements, policies and procedures, including the privacy and security of confidential information obtained during my visit at CRMC at all times, whether I am off-campus or within CRMC facilities. Confidential information includes any medical information relating to patient care - including, but not limited to, Protected Health Information - privacy information - including, but not limited to dates of birth and social security numbers for patients - and CRMC's confidential business information - including, but not limited to billing practices, accounting information, human resources information or information from other administrative areas.

I understand that I am legally bound to comply with restrictions on sharing Personal Health Information obtained while at CRMC

I acknowledge Cullman Regional Medical Center's Confidentiality statement and that it is my responsibility to become familiar with the information regarding Confidentiality/HIPAA. I also understand that it is my responsibility to consult my instructor, the department director (or designee) if I have any questions regarding policies and/or procedures during my visit at CRMC.

Student Verification - Multi Signature Form

Medication Administration Disclaimer:

I understand that as a student I am *NOT* allowed to dispense /administer medication in any form without the supervision of a licensed CRMC employee or a licensed clinical instructor from the college I am attending. I understand that dispensing medications while unsupervised as a student is practicing without a license. I understand that if I dispense/administer medications while unsupervised this will result in my privileges as a student at CRMC being revoked. (Sign even if student does not dispense/administer medication)

I verify that I have read and understand the information presented in Cullman Regional Hospital Orientation Packet. I have been given the opportunity to clarify any part of the information I may have questions/concerns about. I understand the expectations of Cullman Regional Medical Center and agree to abide by its policies, procedures, requirements, and practices during my assignment here.

PRINT NAME	SIGNATURE	DATE	PHONE / CONTACT #
1.		/ /	
2.		/ /	
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The student has completed the orientation packet. I also understand that while practicing as a student at Cullman Regional the student will not be allowed to dispense/administer medication unsupervised while at bedside.

Program Director / Clinical Instructor / Designee / Verification:

Print Name: _____

Sign Name: _____ Date: _____/_____/_____

Phone /Contact Number: _____2nd #_____

Clinical Area Supervising: (i.e.-3 west) _____