



Student Acknowledgment of Orientation

- In order to add a digital signature to a form, please download the form and open in Adobe Acrobat
- I have read the orientation guide and received additional information and instruction, as it pertains to my assignment, about Hospital policy, procedure, and practice.
- I agree to abide by the “Living Direct” Values of UKHC.
- I understand the expectations, and I agree to abide by Hospital policy, protocols, and standards of practice during my assignment at University of Kentucky Hospital.
- I have read the orientation guide and received additional information and instruction, as it pertains to my assignment, about Hospital policy, procedure, and practice.
- I understand the expectations, and I agree to abide by Hospital policy, protocols, and standards of practice during my assignment at University of Kentucky Hospital.

Additional Information provided by Clinical Instructor:

- ____ 1. Layout of unit (supplies, reference books, Fire alarm, extinguisher, evacuation route, etc.).
- ____ 2. Use of Nursing Flowsheets and documentation system
- ____ 3. Where to store personal items
- ____ 4. Teaching Sheets & Resources
- ____ 5. Resources for Patient Care: Care Coordinators, Case Managers, Support Services
- ____ 6. Unit Routines (VS, Weights, Baths, etc.)
- ____ 7. Medication System (PYXIS and/or E-MAR)
- ____ 8. IV set ups and infusion devices
- ____ 9. Standard and Specialty Beds (if applicable)
- ____ 10. Restraints (if applicable)
- ____ 11. Emergency situations and codes
- ____ 12. Other equipment, procedures, standards: _____
- ____ 13. Use of Social Media/personal email
- ____ 14. Infection Prevention and Control information including COVID-19 from UKHC and school

HIPAA

____ I have reviewed and understand the HIPAA privacy rules restricting use and disclosure of protected health information. I further understand that I am required to comply with the HIPAA rules and that my compliance with them is a condition of my employment, enrollment or affiliation with the University of Kentucky. I understand that failure to follow the HIPAA rules may result in disciplinary action, including termination of my employment, enrollment or affiliation at the University.

I further understand that should I violate any of the provisions of the HIPAA law I will not be covered by the University’s liability insurance and therefore will be personally responsible for any fines, penalties, or imprisonment.

Insurance Certification

____ I acknowledge that the University of Kentucky requires all persons doing clinical rotations at its facilities to have and maintain a health insurance policy. I understand that it is my responsibility to acquire and maintain a health insurance policy throughout the duration of my rotation at the University of Kentucky. I shall provide evidence of such health insurance policy in whatever format is deemed acceptable by the University of Kentucky. I understand that should I fail to obtain a health insurance policy, let my current health insurance policy lapse, or in any way not be covered by a health insurance policy deemed acceptable by the University of Kentucky, my enrollment or affiliation with the University of Kentucky may be terminated.

I hereby acknowledge the University of Kentucky’s policy on health insurance coverage, and agree to adhere to its terms.

Student Name (print): _____ Student Signature: _____ Date: _____

School: _____ Dates/Times on Unit _____ Unit: _____

Faculty/Preceptor Signature: _____

UK Health Care Confidentiality Agreement for Computer Use

Applicant's Name _____ UK ID #: _____ Date of Birth: _____

I understand that my access to data, information, and records maintained in the manual and automated information and records systems of UK HealthCare (all hereinafter referred to as Information Systems) is limited to my need for the information in the performance of my job duties. UK HealthCare restricted information may include, but is not limited to, financial data, patient health information (PHI), personally identifiable information (PII), contract information, and data that results in a competitive advantage in the marketplace regardless of its form (i.e. paper, magnetic media, optical media, conversations, film, etc.). The intent of this agreement and UK HealthCare policies is to assure that restricted information will remain confidential through its use, only as a necessity to accomplish the organization's mission.

By my signature below, I affirm that I have been advised of, understand, and agree to the following terms and conditions of my access to information contained in Information Systems.

- My computer logon ID/password combination is equivalent to my LEGAL SIGNATURE and I will not disclose this password to anyone or allow anyone to access Information Systems using my logon ID/password combination.
- I will password protect and encrypt any portable electronic device that contains patient (or other restricted) information.
- I am responsible and accountable for all entries made and all retrievals accessed using my logon ID/password, even if such action was made by me or by another due to my intentional or negligent act or omission.
- I will not access any Information System using a logon ID/password other than my own.
- I will not access or request access to any information for which I have no responsibility. In addition, I will not look up my own medical information.
- If I have reason to believe that my logon ID/password has been compromised, I will immediately notify the Office of Corporate Compliance and the Director of Information Security.
- I will not disclose any restricted information unless required to do so in the official capacity of my employment or contract. I also understand that I have no right of ownership interest in any restricted information.
- I will comply with all policies and procedures and other rules of UK HealthCare relating to confidentiality of information and access.
- I understand that my use of the UK HealthCare Information Systems may be periodically monitored to ensure compliance with this agreement.
- I will dispose of restricted information properly in accordance with all applicable policies.
- If a Department standard is more restrictive than this agreement, I will abide by that Department's standard.
- I agree not to use the information in any way detrimental to the organization and will keep all such information confidential.
- This agreement cannot be terminated or canceled, nor will it expire.
- I understand that if I violate any of the above terms, I will be subject to disciplinary action, including discharge, loss of privileges, termination, legal action, or any other

Student Signature

Date

Emerging Diseases/COVID-19 Questionnaire

First name:		
Last name:		
Preferred contact number:		
School:		
Preceptor/Sponsor:		
Please respond to the following questions:	Yes	No
Do you have a new cough unrelated to seasonal allergies?		
Do you have new muscle aches/pains?		
Do you have new shortness of breath?		
Do you have a new sore throat (not associated with seasonal allergies)?		
Do you have vomiting or diarrhea?		
Do you have a fever of 100.0 or greater?		
Have you experienced a loss of taste or smell?		
Have you or any of your close personal contacts been diagnosed with COVID-19, within the last 14 days and are you required to isolate by the local health department?		
Have you or any of your close personal contacts traveled to the Democratic Republic of the Congo (DRC) or Guinea in past 30 days?		

Any “yes” responses must be cleared through UK HealthCare Infection Prevention and Control.

If “yes” to any of the above questions, please contact **UK HealthCare Infection Prevention and Control at 859-323-6337** prior to presenting to any UK HealthCare facility for orientation, work assignment, or clinical/learning experience.

Signature of individual completing form: _____ Date: _____

Name of agency/instructor reviewer: _____ Date: _____

For any “yes” answer, contact Infection Prevention and Control (IPAC):

IPAC rep. name: _____ Cleared for work/clinical: ____ Yes ____ No





Student Exit Feedback

Please have students copy and paste the below link into an internet browser at the end of their clinical rotation/synthesis experience or use the QR code to access the survey.

We appreciate you sharing this information with us in an effort to improve educational experiences and opportunities at UK Healthcare and Kentucky Children's Hospital.

https://uky.az1.qualtrics.com/jfe/form/SV_4ZNhdFFKJzkcLeC

