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**Internship Application Packet**

Welcome to Western Missouri Medical Center (WMMC), and thank you for your interest to intern with us. In this Internship Application Packet are the forms, information and requirements which need to be met before you can intern at WMMC.

The Internship Application Packet must be completed in full and returned to the Education Office, **prior** to the beginning of your internship experience. No one will be allowed to intern without completing this packet.

**Checklist**

**The following items must be completed and read/understood before you will be appointed to a department/unit to intern at WMMC.**

* Internship Application (page 3)
* Health Statement (page 4)
* Rubella immunity/immunization documentation – copy of shot record
* TB skin test\* documentation – negative result within the previous 12 months

***\*If an individual’s TB test was previously positive, or if for any reason a skin test is contraindicated, documentation of a current (within the previous 12 months) negative chest x-ray is required. Johnson County Community Health Services offers TB Tests ($10.00); call 660/747-6121 for more details.***

* School or College Internship Coordinator Recommendation (page 4)
* “Confidentiality… Is Your Business!” and Confidentiality Test (page 5-7)
* Code of Conduct (page 8)
* Confidentiality of Information Agreement – HIPAA (page 9)
* Internship Approval and Placement Agreement (page 10)
* Hand Hygiene (page 11)
* Codes at Western Missouri Medical Center (page 12)
* Name Badge (appointment made by Education Office with Human Resources)

***All signatures must be included for application to be complete.***

Return your completed Internship Application Packet, by mail or bring it to:

Jennifer Evert LPN

Education Coordinator

Western Missouri Medical Center

403 Burkarth Road

Warrensburg, Missouri 64093

The hours of internship may vary, depending on the department/unit.

Approval must be given by the Director over the area in which you wish to intern

and will be arranged through WMMC’s Education Office.

**Unless other arrangements have been made, when you arrive at Western Missouri Medical Center on the first day of your internship, please report to the Education Office and you will taken to your assigned area.**

If you have any questions, please feel free to call Jennifer Evert at 660-262-7470.

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**Internship Application**

Applicant’s Name: Date:

Date of Birth: Age: Sex: Male Female

Street Address:

City: State: Zip:

Home Phone: Cell Phone:

Email Address:

School/College Attending:

Supervising Professor/Instructor Name:

Emergency Contact: Relation:

Emergency Contact Phone:

**Please answer the following questions.**

Why are you interested serving as an Intern at Western Missouri Medical Center?

Explain what you hope to gain by interning at WMMC. *(Please be specific.)*

Department/Unit of WMMC you would like to intern:

Required number of internship hours:

Date(s) requested for internship:

|  |
| --- |
| **Indicate the times you will be available to intern for each day.** |
| Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |

**Western Missouri Medical Center**

**Health Statement**

To the best of my knowledge, I, *(applicant)* am free from any conditions, chronic and/or contagious illness which would prevent me to Intern at Western Missouri Medical Center.

Additionally, I have provided the following documentation:

 ~ Current rubella immunity/immunization (copy of shot record).

 ~ TB skin test, with negative results (within the previous 12 months—see note

on page 1.)

Please indicate if there are any conditions which special accommodations might be needed.

Intern - Printed Signature Date

**School or College Internship Coordinator Recommendation**

I verify that this applicant, , is currently a student at .

I recommend the above applicant to participate as an Intern at Western Missouri Medical Center.

Coordinator Signature:

Printed Name:

Title/Position: Date:

Contact Phone Number:

**Confidentiality… Is Your Business!**

An essential part of Western Missouri Medical Center’s values is honoring the dignity of every individual, whether patient, visitor or employee, and ensuring their right to privacy. Every healthcare worker is charged with handling patient confidentiality issues appropriately. People trust us with their most private information and trust us to keep that information private.

**Patient confidentiality means that we keep *all* information**

**about patient’s healthcare private, indefinitely.**

**WHEN WE PERFORM OUR JOBS WE NEED TO INSURE THAT WE**

**DO NOT BETRAY THAT TRUST AND BREACH CONFIDENTIALITY.**

![j0282916[1]]()

**Breach of Confidentiality**

This occurs when private and protected information is improperly given out, either intentionally or unintentionally. Breach of confidentiality is a serious matter because it can emotionally damage the client as well as members of the family. It can make them feel a lack of confidence in the providers as well as in the institution providing the care. Patients may not share important health information if they are afraid it will not be kept private.

**Confidential Information**

Information known or contained in a patient’s medical record, or a person known to the job shadow/observer, shall be treated as confidential and their personal information will not be released by any working or observing, under any circumstances. This includes a wide variety of information about a patient’s care.

Examples consist of:

* Details about illnesses or conditions.
* Medical tests results.
* Information about treatments or response to treatments.
* Prognosis.
* Communication between the patient, family, physicians, and friends.

**Basically, if you aren’t sure whether you should talk**

**about the information or not, DON’T.**

![j0234329[1]]()

**How Does a Breach Occur?**

* Rumors/Gossip.
* Talking in public areas.
* Unauthorized disclosure.
* Failure to secure recorded or computerized information.
* Not paying attention or thinking about what you’re doing.

**Who is Authorized to See Confidential Information?**

* **Staff with “The Need to Know”**

 No patient consent is required to share information with people who need it for the patient’s care, quality assessment, billing or maintaining and distributing records. However, this information is only on a “need to know” basis.

* **The Patient**

 Information in a patient’s record belongs to the patient. A healthcare provider can deny a patient their record only if releasing it would injure the patient.

* **Others**

 Some people such as insurance provider, courts, law enforcement officials, attorneys, and other government agencies may have access to patient information if certain criteria are met.

![j0424446[1]]()**Who Should Not See Confidential Information?**

* **Staff Who Don’t Have “The Need to Know”**

 Staff do not have an automatic right to see or hear

 confidential patient information. To see a patient’s

 information, an employee must need it to provide care or

 perform their job.

* **Unauthorized Friends and Family**

 Friends and family do not have an automatic right to an

 adult patient’s confidential information. Be sure you

 have written approval from the patient before you give

 information to anyone—even loved ones or close friends.

**Protecting Patient Confidentiality**

Information exists in all forms within an institution. Data can be distributed by way of written medical or business records, faxes, computers and other storage media such as microfilm. We need to look at how we do our job and our routines, our recordkeeping procedures and our interactions with others, in order to minimize accidental disclosure of confidential information.

**Verbal Communications**

**Do not talk** about patients in any public place to your friends or any family members. Do not discuss confidential information where others (including other patients, visitors and/or staff) might overhear. Personal opinions as to the competence of hospital staff or medical staff members are not to be expressed to anyone, including family members.

**To Conclude**

Confidentiality is the basis of our patient relationship. Maintaining it really boils down to one thing ~ handling patient information responsibly. All individuals observing at WMMC and having access to any patient, staff member or physician MUST HOLD all information in strict confidence, thus abide by the ***Health Insurance Portability and Accountability Act (HIPAA)*** regulations.

**If we treat information as if it were our own,**

**we will guarantee that it is handled in a manner consistent**

**with the values and standards set by Western Missouri Medical Center.**

*(Adapted and used with approval from St. John’s Hospital – Lebanon, MO)*

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**Confidentiality Test**

Name: Date:

**Please circle the correct answer.**

1. Patient confidentiality means to keep information about a patient’s health private.

True False

1. It is permissible to share a patient’s information with people who need it for the patient’s care, quality assessment, billing, or maintaining and distributing records.

True False

1. All friends and family have an automatic right to an adult patient’s confidential information.

True False

1. Your best friend’s aunt is a patient in your area. Your best friend is curious to know the results of some of her aunt’s resent tests and asks you about them. You should:
2. Graciously obtain the x-ray results for your friend.
3. Graciously state that she will need to ask her aunt for that information.
	1. After your experience at WMMC, a friend asks you who you saw while you were here. You reply by:
4. Listing the names of the people you saw, especially those your friend would know, and why they were at WMMC.
5. Telling them that you would be breaking confidentiality laws. As an alternative share with them what you learned while you were here.



**Code of Conduct**

**As an Intern applicant, I will agree to abide to the following:**

* In making this application to serve as an intern at Western Missouri Medical Center (WMMC), I understand that I must abide by all WMMC policies and procedures. I will follow any unit specific rules that are explained to me.
* I understand that I must respect each patient’s and staff member’s privacy and right to confidentiality and will not seek information regarding specific patients. I will not discuss with anyone outside of the organization, names or information I may come upon during my experience here.
* I understand I must keep confidential any information I may observe during the course of my internship experience. If a violation of privacy does occur even after the experience, your school/college may be in jeopardy of not being allowed to send students in the future to intern at WMMC.
* **I will dress appropriately as specified by my assigned department/unit. NO low-cut, low hanging, spaghetti strap tops, NO blue jeans or shorts and NO flip-flops will be worn.**
* I understand that I must wear my identification badge at all times while I am at the Medical Center serving as an intern during the dates agreed upon. I may not use my ID badge to gain access to any Medical Center areas, which are not within the realm or scope of my approved program. When my internship is complete, I will return my ID badge to my WMMC supervisor or Human Resources.
* I understand that any action unbecoming will not be tolerated. The use of obscene language will not be tolerated. ***WMMC is a tobacco-free environment, thus no tobacco products will be allowed in or on any owned or leased buildings, grounds, parking lots, ramps, plazas, vehicles and sidewalks adjacent to our properties.***
* I will not damage, deface or destroy any WMMC property. If this occurs, I may be held responsible for any/all damages.
* I agree to be punctual and conscientious. I will treat others with dignity, courtesy and consideration.
* I understand that I may compromise the health of the patients, staff and visitors if I am experiencing any of the following conditions: upper respiratory infection, diarrhea or skin lesions. Thus I will not come to WMMC and will call my WMMC supervisor to let them know I will not be coming on the designated day(s). Additionally, I understand that if these conditions occur during my assigned hours, if appropriate, I may be asked to leave the Medical Center.
* I understand that approval for this program is for a specified length of time and that failure to meet any of the internship requirements shall cause approval to intern to be forfeited.
* I understand that during my participation in this program I may be exposed to patients who have contagious diseases as well as to blood and bloodborne pathogens. I accept this risk and should I contact an illness from such exposure, hereby release Western Missouri Medical Center from any liability.
* I understand that if an accident should occur while interning, I accept the responsibility for any medical treatment and/or expenses which may be required, hereby release Western Missouri Medical Center from any liability.

I agree to abide by the above conditions and by not doing so could result in dismissal from my internship at Western Missouri Medical Center.

Intern - Printed Signature Date

**Western Missouri Medical Center**

**Confidentiality of INFORMATION AGREEMENT**

**- HIPAA Privacy Policy and Procedure -**

I, , have been informed of and understand Western Missouri Medical Center’s HIPAA Privacy Policies and Procedures regarding the privacy of Protected Health Information (PHI), as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, I acknowledge that I have received training in the HIPAA Privacy Policies and Procedures regarding PHI use, disclosure as required by HIPAA.

In consideration of my observation at Western Missouri Medical Center, I hereby agree that I will not at any time – either during my association with Western Missouri Medical Center or after my association ends – access, use, or disclose PHI to any person or entity, internally or externally, except as is required and permitted in the course of my duties and responsibilities with Western Missouri Medical Center, as set forth in the HIPAA Privacy Policies and Procedures or as permitted under HIPAA. I understand that this obligation extends to any PHI that I may acquire during the course of my association with Western Missouri Medical Center, whether in oral, written, or electronic form, and regardless of the manner in which access was obtained, by patient, hospital staff, physicians, volunteers or any person(s) associated with Western Missouri Medical Center.

I understand and acknowledge my responsibility to apply the Privacy Policies and Procedures during the course of my association. I also understand that unauthorized use or disclosure of PHI will result in disciplinary action, up to and including termination of my association with Western Missouri Medical Center, and that I could be subject to the imposition of civil or criminal penalties under applicable federal and state law, as well as professional disciplinary action as appropriate.

I understand that this obligation will continue at the end of my association or termination with Western Missouri Medical Center.

Intern - Printed Signature Date



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**Internship Approval and Placement Agreement**

**Internship Application Packet is considered completed and approved with the completion of the following:**

***Intern Applicant’s Name & Signature***

By signing below, you agree with all the information contained in the Western Missouri Medical Center Internship Application Packet and will keep confidential all information heard and/or seen either directly or indirectly concerning patients, physicians, staff or volunteers.

Intern - Printed Signature Date

***Thank you for your interest to intern at WMMC.***

***If you have any questions,***

 ***or need to contact the our Education Office for any reason,***

***please call Jennifer Evert at 660-262-7470.***

**To be completed by WMMC Education Staff:**

Documentation of:

* Rubella immunity/immunization documentation.
* TB skin test\* documentation – negative result.

Name Badge (Human Resources): Yes No

Department/Unit Placed:

Approved Date(s):

Days/Time: Sun Mon Tue Wed Thu Fri Sat

Education Staff– Initials Date

***Remove this page to keep as a reference.***

**HAND HYGIENE**

**Appropriate hand hygiene is essential in the prevention and spread of disease.**

![j0371340[1]]()

**OBJECTIVE:**

To provide guidelines for general practices related to hand hygiene of healthcare interns/job shadowing/observers and to reduce transmission of pathogenic microorganisms to patients and personnel at Western Missouri Medical Center.

Proper “hand hygiene” is the single MOST important factor in the prevention or spread of disease.

Hand hygiene shall be performed:

1. Before having direct contact with patients.
2. After handling contaminated materials and equipment.
3. After contact with a patient’s intact or non-intact skin, body fluids or excretions, mucous membranes and wound care.
4. During patient care, when moving from a contaminated-body site to a clean-body site.
5. After contact with inanimate objects including equipment in the immediate vicinity of the patient.
6. Before preparing food, water or medication.
7. Prior to donning sterile gloves.
8. After removing sterile gloves.
9. BEFORE eating and AFTER personally using the restroom.



If using an alcohol-based hand rub:

* + Apply approximately 1-teaspoon to palm of one hand.
	+ Rub hands together, until hands are dry.
	+ If done correctly, should take approximately 15 to 20 seconds to dry.

If using antimicrobial soap:

* Wet hands with water that is NOT hot.
* Hands hold lower than elbows above the sink.
* Apply enough soap to work up a good lather.
* Rub hands together vigorously, covering all surfaces of the hands and fingers.

![j0397038[1]]()If done correctly, you should be able to hum or sing “*Twinkle, Twinkle Little Star”* in its entirety, during the time it takes to wash hands.

* Rinse hands with water and dry thoroughly with a disposable towel.
* Use the towel to turn off faucets and open the door.
* Throw used towel(s) into trash receptacles.

**Codes at Western Missouri Medical Center**

The following is a summary of emergency codes including their meaning and your requested response.

**Code Red:** This is the code name for a fire. If you see obvious signs of fire near you, leave the area immediately, otherwise stay in your area unless asked to evacuate. Do not use elevators or open closed fire doors. Follow instructions.

**Code Gray:** This is the code name for a tornado warning. If you are located on the upper floor or in the west lobby you are asked to evacuate to the lower level internal corridors. Do not use elevators and stay away from windows. Follow instructions from hospital personnel.

**Code Green:** This is a code name for a disaster (externally or internally). Follow instructions from hospital personnel.

**Code Blue:** This means that someone needs life-saving assistance by the hospital’s Code Blue Team. Stay clear and do not block hallways.

**Code Adam:** This is the code name for an abduction or elopement of an infant or child 14 years or under. Be alert and notify any staff member if you suspect that you saw an infant or child leaving or being taken from the building.

**Code Elopement:** This code refers to the elopement or abduction of an adult or older minor child. Be alert and notify any staff member if you suspect that you saw such an individual leaving or being taken from the building.

**Code A & D:** This is the code name used to convey that someone is armed and dangerous in the building. Seek cover in rooms with doors closed, and lights off. Get behind any object (curtain, cabinet, wall, etc.) that helps you be out-of-sight of the intruder. Follow instructions of hospital or law enforcement personnel.

**Code Support:** This is an internal code for hospital staff to respond to assist with an out-of-control individual. Stay out of the way and follow the instructions of hospital personnel.

