

# OUR LADY OF THE LAKE

## REGIONAL MEDICAL CENTER

*Franciscan Missionaries of Our Lady Health System*

### MEDICAL STUDENT APPLICATION CHECK LIST

**Please use the checklist below as a guide for assuring that your application packet is complete. Please return all paperwork to the OLOLRMC GME office no later than 5 business days before the start of your scheduled rotation. All forms and items must be completed, signed and dated in order for your application to be processed.**

#### **Enclosed Forms:**

- Completed Medical Student Application
- Medical Student Rotator Acknowledgement Agreement
- Systems Access and Confidentiality Agreement
- Teaching Program Letter
- Sponsoring Physician Letter- *Students may have this signed by their supervising physician on the first day of their rotation.*

#### **Additional Required Attachments:**

- Proof of Malpractice Insurance Coverage

**Our Lady of the Lake Regional Medical Center**  
*Medical Student*  
*Advanced Practice Registered Nurse Student*  
*Physician Assistant Student*  
**Student Rotator Application Form**

Today's Date: \_\_\_\_\_

**I . IDENTIFYING INFORMATION**

Last Name:	First Name:	Middle Name:	Other Name(s) Used in Training:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Citizenship:	
Date of Birth:	Birth Place (City/State/Country):	Social Security Number:	

**II . ADDRESS**

Home Address: (No P.O. Boxes)	Cell:
City, State, ZIP Code	E-mail Address:

**III. EDUCATION**

Name of School:	Current Year	Date Anticipated Graduation:
Street Address:		
City:		State/Zip & Country:
Name of program currently enrolled in:		
Please indicate any licenses held (indicate license number and expiration):		

**IV. EMERGENCY CONTACT**

Name:	Relationship:
Address:	City, State, Zip:
Phone:	

**V. APPLICANT SIGNATURE**

Signature of Student Applicant: _____
Date: _____

# MEDICAL STUDENT ROTATOR ACKNOWLEDGEMENT AGREEMENT

With regard to my **[insert name of Medical School]** (“School”) clinical rotation at Our Lady of the Lake Hospital, Inc. (“Hospital” or “Facility”) to gain practical experience in the practice of medicine, I agree to abide by the following terms and conditions:

1. I acknowledge and agree that I am covered by professional medical liability insurance as required in the Medical Student Training Affiliation Agreement (“Affiliation Agreement”) between the School and Hospital. Proof of Insurance coverage is required prior to the start of the clinical rotation.
2. I acknowledge and agree that my activities will be under the supervision and control of my attending physician, and I will take no independent action at the Facility related to patient care which is not authorized within the clinical activities established by the “Our Lady of the Lake Hospital, Inc. Medical-Dental Staff Bylaws and Rules and Regulations”, Hospital’s Policies for Clinical Rotations, School’s regulations and guidelines and the Affiliation Agreement.
3. I agree to ensure that all chart entries made by me on any patient record are personally reviewed and countersigned by my attending physician within the time limit prescribed by Hospital rules and regulations and/or applicable medical education norms and customs.
4. I acknowledge that I am not a fully trained practitioner or allied health professional, am not an employee of Our Lady of the Lake Hospital, Inc., and am not a member of the Medical Staff, and I agree to make no representation to the contrary to anyone. Further, I agree that at all times while I am at the Facility, I will wear appropriate identification as may be designated by the Hospital reflecting my status.
5. I agree that at all times while at the Facility, I will observe all rules and regulations of Hospital as set forth in its bylaws, policies and regulations, as may be amended, including but not limited to random drug testing, and to fully comply with the standards of The Joint Commission and the Ethical and Religious Directives for Catholic Health Care Services and Catholic Social Teachings, as amended. I further agree to abide by all federal, state and local laws and regulations including, but not limited to, any applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) regarding the protected health information I may encounter during the term of this agreement.
6. I acknowledge that the Hospital may, at any time with or without cause, terminate its consent to permit me to continue the clinical rotation at the Facility, and I understand such termination can be made immediately if requested by my attending physician or other authorized individual.
7. I agree to hold all confidential, proprietary, and privileged information concerning the operation of Hospital and/or Facility and its patients in confidence.
8. I agree to conform to the standards and practices established by the School while at Hospital and/or Facility.

9. I agree to not submit for publication any material relating to my clinical experience without the prior written approval of Hospital.
10. I certify that I have never been excluded, debarred, suspended, or otherwise ineligible to participate in federal programs including Medicare and Medicaid.
11. I hereby authorize the release to Our Lady of the Lake Hospital, Inc. its employees, officers, directors and any other representatives, and its medical/dental staff, any and all information and documentation, recommendations, reports, statements or other information in connection with verification and evaluation of information pertaining to my clinical rotation or otherwise relating to my clinical competence, professional conduct, character, ethics, behavior or other matters bearing on my qualifications.
12. I extend absolute immunity to, release from any and all liability and agree not to sue Our Lady of the Lake Hospital, Inc., or any other representative of Our Lady of the Lake Hospital, Inc., or its Medical/Dental Staff, for their acts performed in connection with evaluating my performance and my credentials and qualifications.
13. I hereby further authorize and consent to the release by our Lady of the Lake Hospital, Inc. or any of its representatives, or its Medical/Dental Staff to other hospitals, medical/dental staffs, educational programs, medical associations and any other persons with a need to know of any and all information the Hospital and medical/dental staff may have concerning my clinical competence, professional conduct, character, ethics, behavior or other matters bearing on my qualifications, AND I extend absolute immunity to, release from any and all liability and agree not to sue Our Lady of the Lake Hospital, Inc. or any other representative of Our Lady of the Lake Hospital, Inc. or, its Medical/Dental Staff, for providing the above-referenced information and documents.
14. By my signature, I declare that all information provided by me or on my behalf, has been submitted truthfully and accurately to my best knowledge and belief.

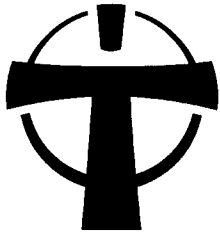
\_\_\_\_\_  
Medical Student's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Student's Printed Name

\_\_\_\_\_  
Medical Student's Address

\_\_\_\_\_  
Medical Student's Telephone Number



**OUR LADY OF THE LAKE**  
 REGIONAL MEDICAL CENTER  
*Franciscan Missionaries of Our Lady Health System*

**TEACHING PROGRAM LETTER**

Name of Student, Intern Resident or Fellow: \_\_\_\_\_

Year in program at time of OLOL rotation: \_\_\_\_\_

Name of the Program: \_\_\_\_\_

Dates of Rotation at OLOL: \_\_\_\_\_

I, \_\_\_\_\_, the undersigned program director, hereby certify the following:

- The above named participant is enrolled and in good standing at \_\_\_\_\_  
 \_\_\_\_\_ (name or program or school).
- The participant has no physical or mental health problems that would interfere with the conduct of medical care as delineated in the written descriptions of the roles, responsibilities, and patient care activities of the participants of medical education programs.
- The participant has fulfilled immunization requirements, documented updated tetanus status, and testing for TB and/or other such infectious diseases as required by federal, state law or regulation, or hospital regulations.
- The participant has other insurance to include health insurance, disability insurance, statutory worker's compensation insurance, employer's liability insurance and comprehensive general liability insurance.
- The participant is competent and qualified to perform patient care activities as delineated.
- A representative from the teaching program has made arrangements for an active member of Our Lady of the Lake's medical staff to serve as a sponsoring physician who has agreed to supervise the participant during his/her tenure at the Hospital.

\_\_\_\_\_  
**Signature of Program Director and Date**

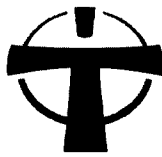
\_\_\_\_\_  
**Signature of Participant and Date**

\_\_\_\_\_  
**Name of Program Director (Print)**

\_\_\_\_\_  
**Name of Participant (Print)**

\_\_\_\_\_  
**Name of School or Program**

**School Address:**  
 \_\_\_\_\_  
 \_\_\_\_\_



**SYSTEMS ACCESS AND CONFIDENTIALITY AGREEMENT**  
**Supplemental Staff/Contracted Services/Medical Staff**

Security, data integrity and confidentiality are matters of concern for all persons who have access to Franciscan Missionaries of Our Lady Health System (FMOLHS) information systems. Measures must be taken to ensure that any such computerized systems in use at FMOLHS and where applicable, FMOLHS off-site subsidiaries and affiliates can only be accessed by authorized users. As an authorized user of the FMOLHS information systems, you have a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their health information.

As a condition to receiving access to information, I, **(Please Print)** \_\_\_\_\_

the undersigned, understand and agree to comply with the following items:

First Name

Middle Initial (Required)

Last Name

1. My User ID and password is the equivalent of my **LEGAL SIGNATURE**. I will not share or disclose my password to anyone nor allow anyone to access any FMOLHS system or application using my User ID.
2. I am responsible and accountable for all activities undertaken using my User ID/Password.
3. I will not attempt to learn or use another person's User ID or password.
4. I will not access any system or application using a User ID other than my own.
5. I will access confidential information only as needed by me to perform my legitimate duties at FMOLHS. This means, among other things, that:
  - a. I will not access confidential information that I have no legitimate need to know.
  - b. I will not in any way divulge, copy, release, sell, loan, revise, alter, or destroy any confidential information except as properly authorized within the scope of my employment.
  - c. I will not misuse, carelessly care for or fail to safeguard confidential information.
6. I understand that I have no right or ownership interest in any confidential information referred to in this agreement.
7. It is my responsibility to log out of the system. I will not leave a workstation unattended to which I have logged on.
8. If I have reason to believe that the confidentiality of my User ID has been compromised, I will change my password. I will immediately report any known or suspected breach of the confidentiality of the system or records/data obtained from it to my immediate supervisor.
9. I understand that my User ID will be inactivated upon notification that I am no longer employed, transferred or have no privileges at FMOLHS or when my job duties do not require access to the computerized systems.
10. I understand that the FMOLHS conducts and maintains an audit trail of accesses to patient information that records the User ID, machine name, date/time, and patient identification.
11. My signature below indicates my understanding of the above noted requirements for the use of any User ID that I am assigned, pursuant to my employment, student, medical staff, or contract responsibilities with FMOLHS.
12. **I agree to abide by FMOLHS' policies concerning the use of computers. I understand the computer and all of its accessories are the property of the hospital and are to be used only for hospital business. FMOLHS reserves the right to examine systems, directories, files and their contents at any time.**

**USER REQUESTING ACCESS – PLEASE COMPLETE THIS SECTION:**

User Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contract Company Name: \_\_\_\_\_ End Date\*: \_\_\_\_\_

Contract Company Phone: \_\_\_\_\_ Last 4 digits of SSN\*\* \_\_\_\_\_

*\*Must be specified, not to exceed 1Year      \*\* For identification purposes only.*

**FMOLHS DESIGNATED REQUESTER – PLEASE COMPLETE THIS SECTION:**

Requestor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Requestor Name (printed): \_\_\_\_\_

*By signing above you acknowledge that all appropriate paperwork has been signed.*

**FMOLHS Helpdesk    Phone: 225-765-4357    Fax Number: 225-765-9904**

## SPONSORING PHYSICIAN'S LETTER

Name of Student, Intern, Resident or Fellow: \_\_\_\_\_

Type of Rotation: \_\_\_\_\_

Location of Rotation: \_\_\_\_\_

Dates of Sponsorship: \_\_\_\_\_

I agree to act as the supervising physician for the above student, intern, resident, or fellow and to undertake the direct supervision of all of the applicant's activities at Our Lady of the Lake Hospital, Inc.

\_\_\_\_\_  
Name of Sponsoring Physician (Print)

\_\_\_\_\_  
Signature of Sponsoring Physician

\_\_\_\_\_  
Date