

Submit to: OLHS.students@ochsnerlsuhs.org for Shreveport and
OLHS-education@ochsnerlsuhs.org for Monroe.

APPLICATION MUST BE COMPLETED AND SUBMITTED ELECTRONICALLY.
HANDWRITTEN APPLICATIONS WILL NOT BE ACCEPTED.

Clinical Student PERSONAL DATA SHEET

Student Demographics

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

Date of Birth: _____ Last 4 Social Security Number: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact's Phone Number(s): _____

College/University: _____

Program of Study: _____ Expected Graduation Date: _____
(MM/YYYY)

Location(s) of Clinical Rotation:

OLHS - Academic Medical Center

Ambulatory Care Center (ACC)

(Select Clinic From Drop Down List)

OLHS - Monroe Medical Center

OLHS - St. Mary Medical Center

1801 Fairfield MOB

(Select Clinic From Drop Down List)

Clinical Department/Rotation: _____

Dates of Rotation - Start: _____ End: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Rotation Type: Group Preceptorship Approx. Number of Hours: _____

Instructor's Name: _____ Instructor's Phone Number: _____

Preceptor's Name: _____ Preceptor's Phone Number: _____

Student Handbook Agreement

(This section to be completed by all students.)

I, (printed name) _____, attest that I have received and read the Ochsner Student Handbook and that I understand and agree to abide by the regulations and procedures as set forth in the Handbook, including but not limited to:

- Parking regulations
- ID badge procedures
- Fire & safety codes
- "Living the Legacy" non-smoking policy
- "The Ochsner Way" (Non-Negotiables)
- Infection Control
- Cell Phone Utilization
- HIPAA & Confidentiality
- Procedures for communicating with a deaf/HOH patient/ Limited English Proficiency
- USP 800
- FERPA

I understand and agree that failure to abide by the terms set forth in the Handbook could result in disciplinary action, up to and including dismissal from my clinical rotation.

Signature: _____ Date: _____

Student Nursing Agreement (LPN, RN, BSN, MSN, DNP)

(This section to be completed by nursing students ONLY.)

I, (printed name) _____, attest that I have received and read the "Nursing Student Rotation Information and Guidelines" section of the Ochsner Student Handbook and that I understand and agree to abide by the regulations and procedures as set forth in the Handbook, including but not limited to:

- Student nurse practice guidelines
- Medication administration
- Occurrence reporting
- APRN guidelines (for all APRN students)

I also attest that I have been oriented by my instructor regarding computer access/use (where applicable) and that I have been oriented to the campus (where applicable) at which my clinical education will take place.

Signature: _____ Date: _____

EXHIBIT A
CONFIDENTIALITY STATEMENT AND STATEMENT OF RESPONSIBILITY

CONFIDENTIALITY STATEMENT

I acknowledge my responsibility and agree to keep confidential any and all information regarding Ochsner Health System (“Ochsner”) patients and proprietary information of Ochsner. The **HIPAA Privacy Rule** prohibits Ochsner from using or disclosing protected health information (PHI) unless authorized by the patient except in certain circumstances and the **HIPAA Security Rule** and the **HITECH Regulations** require Ochsner to safeguard the Confidentiality, Integrity and Availability of electronic protected health information (ePHI) against unauthorized use or disclosure. I have read the material on both HIPAA Privacy and Security and HITECH and agree to comply with these policies and this confidentiality statement and statement of responsibility. Patient, employee and business information is privileged and confidential and any unauthorized or inappropriate release, use and/or discussion is a serious matter which may result in dismissal from the clinical educational program.

My user ID, and the “Password” I choose are my own individual, personal codes for gaining access to electronically stored information. I will not disclose or share them with any other person. My user ID and Password are the equivalent of my personal signature when performing all computer activities and as such, are legally binding. If I share my User ID and Password, use someone else’s user ID &/or Password, access my own medical records or otherwise fail to comply with above mentioned Ochsner’s Security Policies, I may be subject to dismissal.

I may not use an Ochsner computer to access my own medical records or the records of my family, friends or co-workers even if ordered to do so by the physician. I will access only the information required in the performance of my clinical education and all information is confidential and to be used only in the performance of my clinical education.

I acknowledge that I have had an opportunity to ask questions regarding all Ochsner privacy and security policies and procedures.

STATEMENT OF RESPONSIBILITY

For and in consideration of the benefit provided in the form of experience in evaluation and treatment of patients at Ochsner, I, on behalf of myself and my heirs, successors and/or assigns do hereby covenant and agree to assume all risks of, and be solely responsible for, any injury or loss sustained by the undersigned while participating in the program at Ochsner unless such injury or loss arises solely out of Ochsner’s gross negligence or willful misconduct.

NAME (PLEASE PRINT)

SIGNATURE

DATE

PROGRAM