# PERSONAL DATA SHEET
## Advanced Practice Provider
## Graduate/Doctoral Nursing or Physician Assistant Students

**Submit to: OLHS.students@ochsnerlsuhs.org**
*PACKET MUST BE COMPLETED AND SUBMITED ELECTRONICALLY.*
*HANDWRITTEN PACKETS WILL NOT BE ACCEPTED.*

## Personal Information

Name: _____
Last First MI

Date of Birth: _____ Telephone Number: _____

Last 4 Social Security Number_____

Have you ever worked at Ochsner?

School E-mail Address: _____ ☐ YES ☐ NO ☐ Current employee

University Student ID Number _____ Previous ADID _____

University/College: _____

I agree that all information provided on this application is true and accurate.

**Applicant's Signature:** _____ **Date:** _____

## Clinical Area

Clinical Area
_____
Clinical Area/Department (please indicate hospital or clinic)

Select Location/Region:
☐ Academic Medical Center ☐ St. Mary Medical Center
☐ Ambulatory Care Center ☐ 1801 Fairfield MOB
☐ Other:_____

**Semester** Select Semester _____ _____ **to** _____
mm/dd/yyyy mm/dd/yyyy

_____
Preceptor Name

## To Be Completed By Ochsner's Academics Department

Date Submitted: _____ Date Application Materials Completed: _____

Notes: _____

_____

# 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: _____

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# 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