MedStar Health

ORIENTATION FOR NURSING FACULTY

MedStar Good Samaritan Hospital
&
MedStar Union Memorial Hospital

PART 2

Mandatory Documents for CLINCAL GROUPS

2021-2022

Revised DEC 2021 CMW

The forms/documents listed in the Documentation Summary are to be completed and turned into the Clinical Placement Coordinator at least thirty (30) days prior to the first clinical day

MedStar Health

Dear Clinical Instructor,

We are delighted that you and your students are using MedStar Good Samaritan Hospital or MedStar union Memorial Hospital for your clinical rotation. We hope that your experience is a good one and welcome feedback and input throughout your clinical rotation.

MedStar North hospitals are making every effort to be in compliance with the agreements established by our Student Placement Committee. Please refer to the Medstar Health Faculty Manual for each Nursing Faculty.

Please read the **Clinical Rotations Guideline: Faculty and Student policy** (October 2020) which can be found in Part I of the Faculty manual Appendix A.

All documents in this section of the Faculty Manual must be completed and signed by the clinical instructor and turned into the Clinical Coordinator 30 days before the first clinical day.

Clinical instructors/schools who do not complete the required documentation will not be permitted to participate in the clinical experience.

Documents for MUMH practicums must be emailed to Lola Kropkowski and Corinne Weigand Sincerely,

Corinne and Lola

Corinne M. Weigand, MA
Nursing Staff Development Specialist
MedStar Good Samaritan Hospital
P 443-444-4705
corinne.m.weigand@medstar.net

Lola Kropkowski, MSN, RN, NPD-BC
Nursing Professional Development Specialist
MedStar Union Memorial Hospital
P 410-554-2493
Lola.kropkowski@medstar.net

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Documentation Summary

Name of School: _____

Instructor's Name: _____

Instructor's Signature: _____

Document	Date	Completed By
Course Objectives	**Submitted by email**	**Instructor**
Current Instructor Resume	**Submitted by email**	**Instructor**
Faculty Information Sheet	**Submitted by email**	**Instructor**
Medication Administration Signature Sheet	**Submitted by email**	**Instructor**
Student Roster	**Submitted by email**	**Instructor & Student**
Confidentiality Statement	**Submitted by email**	**Instructor & Student**
Technology User Confidentiality Agreement and Acknowledgement of Responsibilities	**Submitted by email**	**Instructor & Student**
Safety, TJC, Infection Control Attestation	**Submitted by email**	**Instructor & Student**
Code of Conduct Attestation	**Submitted by email**	**Instructor & Student**
PPE – SITEL Transcript	**Submitted by email**	**Instructor & Student**
Certificate of Student Requirements [COVERS - health insurance/health screening/COVID & FLU Vaccine/drug test/background check]	**Submitted by email**	**School Administration**
Student MedConnect Request Form	**Submitted by email**	**School Administration**
Faculty MedConnect/Pyxis Request Form	**Submitted by email**	**School Administration**
****Faculty Evaluation of Clinical Experience**	****Submit at end of clinical**	
****Staff Evaluation of Clinical Experience**	****Submit at end of clinical**	
****Student Evaluation of Clinical Experience**	****Submit at end of clinical**	

Instructor's Mandatory COVID Vaccine Record	**On file at school**	
Instructor's Mandatory Flu Vaccine Record for Current Year		
Instructor's Health Screening	**On file at school**	
Instructor's Mandatory Training & HIPPA Training	**On file at school**	
Instructor's CPR Card	**On file at school**	
Instructor's License		
Student's Mandatory COVID Vaccine Record	**On file at school**	
Student's Mandatory Flu Vaccine Record for Current Year	**On file at school**	
Students' Health Screening	**On file at school**	
Student's Mandatory Training & HIPPA Training	**On file at school**	
Student's CPR Card	**On file at school**	
Student's RN License (RN-BSN or Master's Student)	**On file at school**	

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Faculty Information

Clinical Instructor's Name _____

Name of School _____

Email Address _____

Cell Phone Number _____

Office Phone Number _____

Additional Information _____

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Medication Administration Signature Sheet

At MedStar we strive to provide our patients with the very best and safest of care. It has been brought to our attention that the area of **medication administration** has been identified as being an area where errors can occur even though nursing students receive close supervision by their instructors. In order to minimize this possibility, we require the following:

- that you and your students are familiar with our patient identification policy;
- that the patient identification policy is followed every time a medication is administered;
- that you and your students are familiar with our medication administration policies and high alert medications. It is our policy that medications are administered within 30 minutes of ordered time. Actual administration time must be documented

Instructors must administer medications with their students and confirm patient identification using 2 identifiers.

- when administering medications, the eMAR is taken to the bedside for all patients except those on isolation;
- that students will utilize the hand held device to administer meds. Instructor must witness and verify each medication on the eMAR in order for medication to be shown as given;
- that medications for only one patient at a time are removed from the Pyxis and administered before the next patient's medications are removed;
- that you remain with the student administering medication **throughout the entire process** (including seeing patient swallow meds);
- that you and your student remain in constant communication with the nurse that has been assigned to your patients.

This document is intended to reinforce and clarify patient safety expectations at MedStar. Please don't hesitate to ask questions or request assistance. We are striving toward a mutually rewarding relationship. We consider you and your students a welcomed and important part of the patient care team. All MedStar Nursing Policies may be found online on the StarPort page. Please ask for assistance if you have any problems accessing this information.

By signing this document, I acknowledge receipt, understanding and willingness to comply with this information.

Instructor _____

Signature/Date_____

School Name_____

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Student Roster

Please complete and submit this form for each clinical group PRIOR to start of the first clinical day.

Name of School:_____

Instructor:_____

Clinical Hospital & Unit:_____

Name (PLEASE PRINT)	Signature	Initials
INSTRUCTOR		
STUDENTS: 1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

MedStar Health

Confidentiality Statement

I understand and agree that as part of my affiliation, training and/or observations on the premises of, or on behalf of, MedStar Entity, Inc. or any of its subsidiaries or affiliates (collectively "MedStar"), I may, both prior to, and while on the premises, have access to, or come in contact with, Confidential Information.

I understand that Confidential Information includes, but is not limited to, any of the following information or materials owned by, or in the possession of MedStar (including any such information created by me in connection with my affiliation, training and/or observations): All business information, personnel information, quality improvement information, utilization management information, risk management information, operational policies or procedures, patient data or information, medical records, promotional and marketing programs, business plans, product specifications, manufacturing processes and operations, information about techniques, analytical methodology, safety, testing data and results, future market and product plans, billing and financial data and information, computer passwords/access rights, trade secrets, work product, intellectual property, and other information of a technical, scientific, or economic nature relating in any way to MedStar.

I understand that all Confidential Information created, obtained, received, reviewed, or which I may have contact with in connection with my affiliation, training, and/or observations, is confidential in nature. I further understand and agree that I shall, at all times ensure the confidentiality of all Confidential Information I have contact with, that I shall not re-disclose such Confidential Information to any other person or entity without prior written approval from MedStar, and that I shall comply with all applicable laws including the obligation to maintain patient privacy. I further agree that I shall only review or access Confidential Information as specifically permitted by MedStar.

I agree to promptly inform appropriate representatives of MedStar of any breach of confidentiality for which I become aware and to reduce the effect of such breach by retrieving any inappropriately disclosed Confidential Information and taking any other actions necessary to minimize the effect of such disclosure or use of such Confidential Information. I understand that a failure to comply with the terms of this agreement may result in disciplinary actions, including but not limited to immediate dismissal, criminal or civil sanctions.

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Instructor _____Signature/Date_____

School Name_____

MedStar Health

Technology Confidentiality Agreement and Acknowledgement of Responsibilities

MedStar Health, Inc. and its subsidiaries (collectively, MedStar Health) are committed to the physical, technical and administrative security of its information technology resources. By my signature below, I understand that my access and use of all MedStar Health information technology resources, including but not limited to, access and use of the MedStar Health network, hardware, and software (collectively "systems") is a privilege and that such access and use are subject to all applicable legal requirements as well as all applicable MedStar Health policies, procedures, and requirements and the applicable policies, procedures, and requirements of the MedStar subsidiary which authorizes my system access and use.

As a condition of my access, I agree to maintain the confidentiality of all MedStar Health confidential business information which I may have the ability to access, including but not limited to, all personnel information, billing and financial information, patient data or medical information, promotional and marketing program information, strategic planning data, business plans, computer passwords/access rights, privileged materials, trade secrets, intellectual property, and other proprietary information relating in any way to MedStar Health.

I further understand and agree that even though I may be granted access to systems which contain large quantities of data as part of my job responsibilities or role within MedStar ("Role-Based Access"), I am only permitted to access, use, disclose specific information as necessary to perform my job function or complete my responsibilities. I understand this means that I am not permitted to access or use any component of the system if I do not have a legitimate professional need to have such access and it is my responsibility to terminate access to any systems I do not need.

In addition, I understand that I am only permitted to access, use and disclose information from the system and its components, or its connected systems, if it is for a purpose permitted under applicable laws and policies ("Purpose-Based Access"). I understand this means that even if when my role would permit me to have access to the system, I am only permitted to access, use, or disclose the information if it is for an authorized and permissible purpose.

I understand that these obligations apply whether the information is held in electronic or any other form, and whether the information is used or disclosed electronically, orally, or in writing.

Acknowledgement of Responsibilities. I understand and agree that:

Administrative, Technical, and Physical Safeguards

The User ID and Password assigned to me are unique and non-transferable and that I will not share my User ID or password with any other individual, permit another person to perform any functions while logged into a system under my User ID or Password, nor will I perform any function using a system under another person's User ID or Password. I will take appropriate measures to protect my User ID

and Password and that I am responsible for all information accessed, used, or altered with the use of my User ID and Password.
I understand that my approved access and use of MedStar's systems is limited to only those systems necessary to perform my job duties or as permitted because of my role
(User Confidentiality Agreement and Acknowledgement of Responsibilities page 2)
and that I must request deactivation of any systems not necessary to perform my duties or responsibilities.
I agree to logoff the system when I leave a workstation and to take such other reasonable steps as are necessary to maintain the physical security of my workstation to ensure that unauthorized persons cannot view or access any confidential, proprietary, or identifiable patient information that I may have access to by virtue of my responsibilities or access rights.
I understand that my approved access and use may be actively recorded, monitored, and/or audited without prior notice (including Internet and e-mail account usage) and that MedStar Health reserves the right to monitor, review, and record individual user system activities (including, but not limited to, the use of personal e-mail accounts). MedStar Health may permit other business partners or law enforcement to monitor, uses, or record such information as permitted or required by law.

Acceptable Uses and Disclosures

- I agree that acceptable use of MedStar Health systems and the disclosure of information from those systems include only those activities which fosters MedStar Health's clinical, research, educational, and business purposes in a manner which promotes the vision, mission and values of MedStar Health and are consistent with MedStar's Code of Conduct and legal requirements.
- I agree to access, use, or disclose system information only in the performance of my duties, where required by or permitted by law, and only to persons who have the right to receive that information.
- I agree that I will not copy, download, print, transmit information in any format, for myself or for any other person, except as I am required to fulfill my responsibilities.
  When using or disclosing information, I will use or disclose only the minimum information necessary.
- I understand that prohibited uses of MedStar's systems (including e-mail and Internet use) include, but are not limited, to any use that
  - Involves illegal activity or threatens MedStar, its users, or its systems in any way,
  - Interferes with the acceptable use of other MedStar users,
  - Is in violation of any MedStar Health policy, procedure or requirements.
- I understand that acceptable personal uses of MedStar systems (including e-mail and Internet use) are severely limited to Activities:
  - Incidental to an acceptable MedStar business use (such as coordinating work and family schedules),
  - That do not cause MedStar to incur additional expenses or interfere with my productivity, or any other clinical or business activities,
  - That does not violate any MedStar policies, procedures or requirements.

Training and Education

I understand that system education and training may be mandatory for each system accessed and that it is my responsibility to fulfill all mandatory training and education requirements necessary for my role as a condition of my system access.

Reporting Requirements

I agree to immediately notify my supervisor and the MedStar Health Information Systems Security Office via the Help Desk (1-410-933-HELP)
If I suspect that someone has gained unauthorized access to my User ID or Password.
If any hardware or software used to access MedStar systems is lost or stolen.

By my signature I understand and agree that my rights to access and use MedStar's system may be immediately terminated without further notice for breaching any terms of this agreement and that such a breach may result in personal liabilities, including but not limited to (as applicable): disciplinary actions up to and including termination of employment, loss of professional privileges, criminal prosecution, civil litigation, referral to appropriate law enforcement authorities, referral to regulatory or licensure authorities, or other remedies as deemed appropriate by MedStar Health.
Reviewed: 7/14, 7/15, 7/19, 7/21

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Print Name_____Signature/Date_____

Instructor _____Signature/Date_____

School Name_____

MedStar Health

Safety, Joint Commission, Infection Control Attestation

School/Agency: _____

I have read and reviewed and understand all the Safety, Joint Commission, and Infection Control information in the faculty manual. I am fully aware of the need to comply with this information.

Name (Please Print)	Signature	Date
Instructor		
Students		

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Code of Conduct Attestation

Name of School: _____

Instructor's Signature: _____ Instructor's Initials_____

By signing this form, I acknowledge that I have reviewed, read, understood the MedStar Code of Conduct information in the faculty manual. Failure to adhere to the Code of Conduct can result in disciplinary action up to and including termination of employment and/or affiliation.

Name (Please Print)	Signature	Date
Instructor		
Students		

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PPE SITEL Module

All students and instructors must submit Transcript showing completion of the SITEL PPE module.

SiTEL On-Line Module Registration: Students & Instructors

MedStar Health

- **Enter the following website: https://www.sitelms.org/home/login/ . This screen will appear.**

Do not create a new account, follow instructions below!!

- **Go to the 'SEARCH CATALOG' section in the top right-hand corner and enter "31430" and click the 'SEARCH' BUTTON. This screen below will appear.**

- **Click the title "MedStar Health COVID-19 PPE Protocols". The following screen will appear.**

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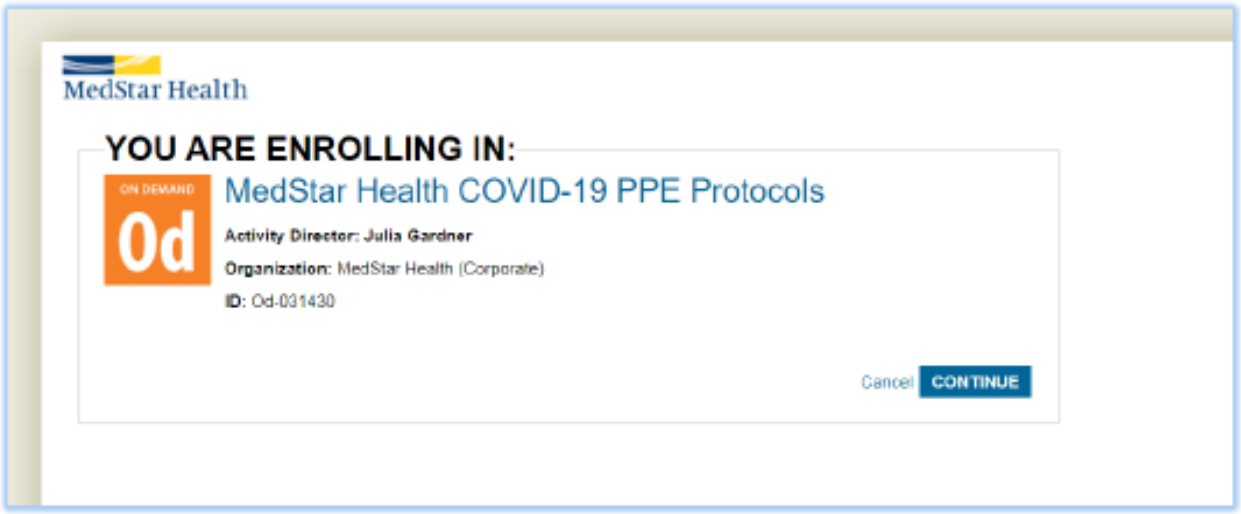
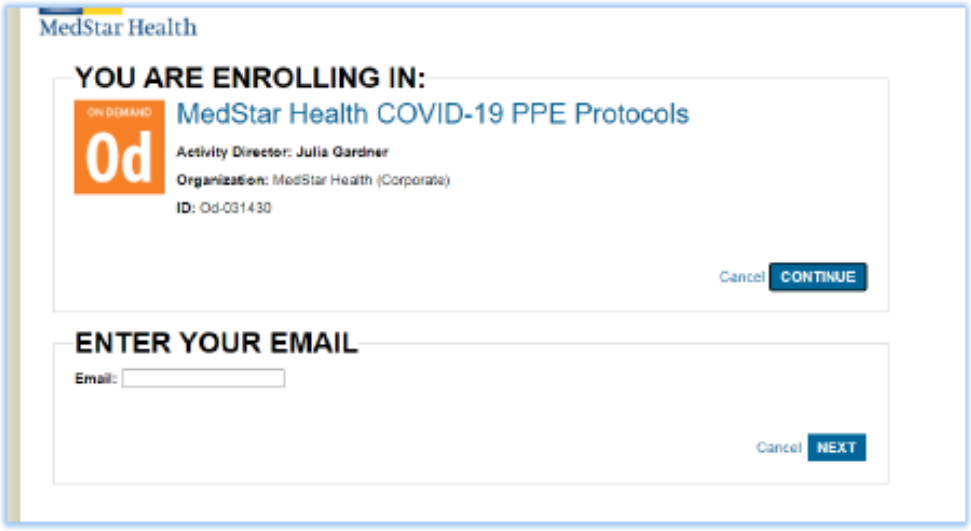
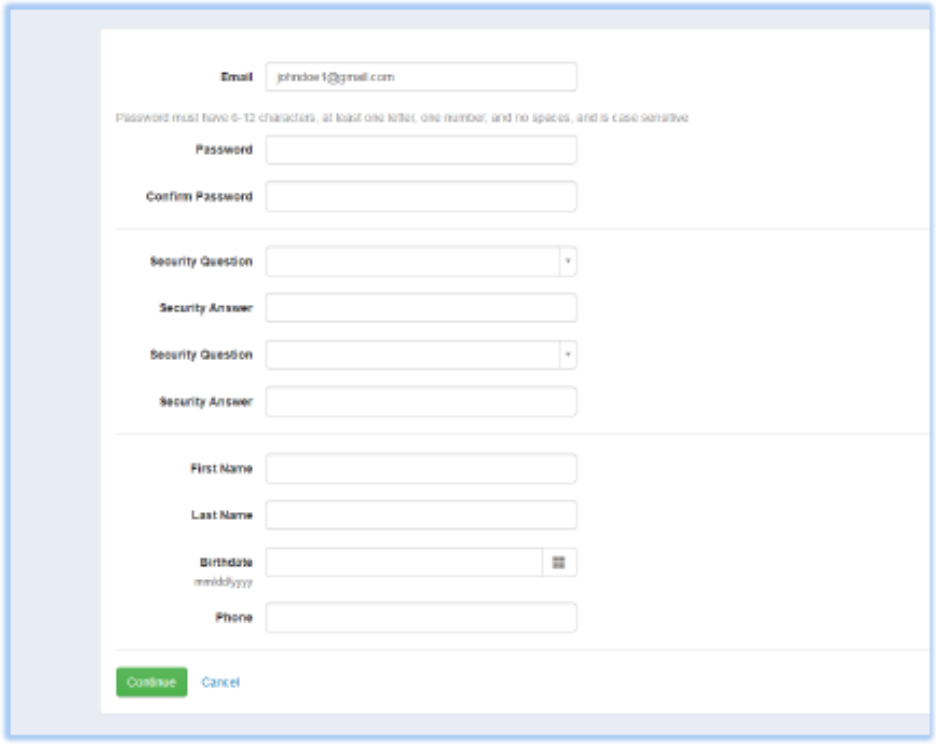
- Click on the "ENROLL" bar. From there this screen will appear.



- Click the "CONTINUE" bar. The following screen will appear.



- Enter your email. Then click the "NEXT" bar. This screen will appear.



- Enter the required information in the blank fields then click the "CONTINUE" bar.

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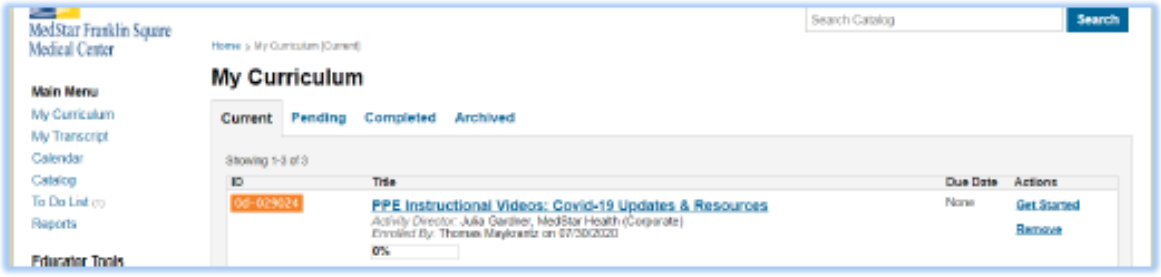
- You can then continue the enrollment process by clicking on the "Enroll" bar. You have created your account and the course you enrolled in will be located in your 'CURRICULUM' on the home page. Click 'GET STARTED' to complete the module.



Once you have completed the module, you can print a copy of your transcript. This module transcript may be used for any MedStar facility if required.

You may use this SiTEL account for any required modules from MedStar Health. The username (email address) and password you selected will not change and your transcripts will be saved for future use.

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Certification of Student Requirements

This completed form must be signed by the appropriate College representative and be returned to the Clinical Placement Coordinator from the entity facilitating clinical experience at least fourteen (14) days prior to the start of the student's clinical experience.

1. The college has notified the student listed on spreadsheet that they should have health insurance and in the event of a Student accident, illness or injury the cost of treatment must be borne by the Student or the Student's health insurance agency. The listed students are in compliance with the Health Screening and Documentation Requirements listed on Attachment C.

2. A criminal background check covering the prior seven (7) years [federal; DC, Maryland, and Virginia; and any other state where the student has lived] was completed on (enter date on form). The records indicate that the student has never been convicted of any of the following offenses:

    a. Murder
    b. Arson
    c. Assault, battery, assault and battery, assault with a dangerous weapon, mayhem or threats to do bodily harm
    d. Burglary
    e. Robbery
    f. Kidnapping
    g. Theft, fraud, forgery, extortion or blackmail
    h. Illegal use or possession of a firearm
    i. Rape, sexual assault, sexual battery, or sexual abuse
    j. Child abuse or cruelty to children
    k. Unlawful distribution, or possession with intent to distribute, a controlled substance

3. A ten (10) Panel non-DOT Drug Test was performed on (enter date on form) and the results are negative.

This must be emailed by the school administration office and NOT completed by the faculty or students.

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Certification of Student Requirements

This must be emailed by the school administration office and NOT completed by the faculty or students.

Nursing School: _____

Nursing Instructor: _____

Start Date of Clinical Experience: _____

Student Name PLEASE PRINT	Criminal Background Check Date	Negative Ten (10) Panel non DOT Drug Test Date

I attest that the student(s) on the above spreadsheet have fulfilled the above requirements and that all documentation evidencing the above information is kept on file at the College and will be made available to MedStar upon request.

_____

(Signature of College Representative) **Date**

_____

(Printed Name of College Representative)

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ATTACHMENT C

Health Screening and Documentation Requirements

Each MedStar Entity has their own health screening and other documentation requirements which may vary due to the nature of the educational experience. Documentation and health screening requirements may include, but not be limited to:

A) Provision to MedStar Entity of all applicable required licenses, permits, certifications or degrees by University upon request, including written documentation that includes:

1. As appropriate, background information on all students prior to their affiliation with MedStar Entity, including but not limited to, a completed application, skills checklist, evidence of training in Universal Precautions as applicable, at least two (2) written professional or technical references as required by MedStar Entity, any applicable Visa information, evidence of continuing education as required by the appropriate professional and/or technical oversight Agency(s), evidence of a satisfactory work history including demonstrated reliability in performance of their duties and a satisfactory attendance as requested by MedStar Entity; and for House Staff, Nursing Staff, Respiratory Therapists and all other Direct patient care providers, University shall also provide current CPR certificate;

2. Evidence of IGRA (T-Spot, Quantiferon gold) or a negative tuberculin skin test by Mantoux PPD within the twelve (12) months prior to the start date (must be updated annually). MedStar Entity's Employee Health Service will update the PPD, at no cost to the University, if due while the individual is affiliated with MedStar Entity. It is the University's responsibility to ensure compliance with tuberculosis screening.

    b) If student's PPD history is positive, University must have on file documentation of a negative chest x-ray performed after identification of the positive PPD. If prior positive history without treatment for latent TB, student is then required to complete an annual questionnaire to identify symptoms of tuberculosis disease (i.e. shortness of breath, productive cough, bloody sputum, weight loss, fever, chills, loss of appetite, generalized swollen glands) and affirmative responses will require referral for evaluation for chest x-ray;

3. Proof of immunity to Measles, Mumps and German Measles (Rubella) by providing documentation of two (2) MMR vaccines; or laboratory evidence of immunity.

4. Laboratory evidence of immunity, or documentation of immunization with two (2) doses of chickenpox vaccine. 4

5. Documentation of completion of three (3) Hepatitis B vaccines or titer result required for positions with potential exposure to blood/body fluids; or if the individual declines the vaccine, a signed statement of declination.

6. For clinical experience under this Agreement, evidence of an annual flu vaccine in accordance with MedStar Entity's influenza vaccine program and policy.

7. For clinical experience under this Agreement, evidence of full COVID-19 vaccination in accordance with MedStar Health's COVID-19 vaccine program and policy

Student MedConnect Request Form

- Student requests be submitted in an EXCEL format and emailed to Corinne Weigand Corinne.m.weigand@medstar.net
- It takes a minimum of 2 weeks to process a request.
- Requests are automated. Therefore, students will be emailed their user ID and password to the email provided in the chart below. Please be careful entering the email address.
- Copy and paste this chart to an excel spreadsheet. Do not add or delete any rows or columns. Only submit one document per clinical group.
- When saving the document please include the school, semester and instructor's name in the title.

sn	givenName	**middle**	**externalEmail**	externalPhone	onsiteremote	previous	userid	purpose	title	vuid	startDate	endDate
Garcia	Mary	A	mgarci69@comcast.net	410.222.2222	Onsite	?		Nursing Student	Nursing Student	573762	9/1/2020	11/1/2020
					Onsite			Nursing Student	Nursing Student			
					Onsite			Nursing Student	Nursing Student			
					Onsite			Nursing Student	Nursing Student			
					Onsite			Nursing Student	Nursing Student			
					Onsite			Nursing Student	Nursing Student			
					Onsite			Nursing Student	Nursing Student			
					Onsite			Nursing Student	Nursing Student			

COLUMN DEFINITIONS
"sn" stands for sur name, so please put their last name in there.
"givenName" is their first name
"externalPhone" needs to be in the XXX.XXX.XXXX format
"previous" answer "Yes" if the student has had a previous clinical or worked for ANY MedStar institution. If yes, please find out user id.
"userid" should be left blank unless they have had a previous clinical or worked for ANY MedStar institution
"vuid" should be their CCBC student ID number
"startDate" needs to be formatted with back slashes, not periods – 8/31/2020 – and have the four digit year.

Faculty MedConnect/Pyxis Request Form

- Faculty requests be submitted in an EXCEL format and emailed to Corinne Weigand Corinne.m.weigand@medstar.net
- It takes a minimum of 2 weeks to process a request.
- Requests are automated. Therefore, students will be emailed their user ID and password to the email provided in the chart below. Please be careful entering the email address.
- Copy and paste this chart to an excel spreadsheet. Do not add or delete any rows or columns. Only submit one document per clinical group.
- When saving the document please include the school, semester and instructor's name in the title.

sn	givenName	**middle**	**externalEmail**	externalPhone	onsiteremote	previous	userid	purpose	title	vuid	startDate	endDate
Garcia	Mary	A	mgarci69@comcast.net	410-222-2222	Onsite	No		Nursing Instructor	Nursing Instructor	573762	9/1/2020	11/1/2020
					Onsite			Nursing Instructor	Nursing Instructor			
					Onsite			Nursing Instructor	Nursing Instructor			
					Onsite			Nursing Instructor	Nursing Instructor			
					Onsite			Nursing Instructor	Nursing Instructor			
					Onsite			Nursing Instructor	Nursing Instructor			
					Onsite			Nursing Instructor	Nursing Instructor			
					Onsite			Nursing Instructor	Nursing Instructor			

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Faculty Evaluation of Clinical Experiences

Name of School: _____ **Instructor: _____**

Hospital: MFSH ___ MGSH ___ MHH___ MUMH___

Unit: _____ Day(s) of the Week: _____

Hours: _____ Semester & Year: _____

We want to thank you for your time and efforts in working with the students in the provision of care to our patients during their clinical rotation. We hope this experience exceeded your expectations and provided your students with a great learning experience. We are interested in your comments and feedback about your experience here. Please take a few minutes and complete the following questionnaire and return it to the Student Placement Coordinator at the site/facility of your clinical experience. Your feedback is important to us. **Thank you!**

1. The clinical experiences contributed to meeting student/faculty goals. ☐ Yes ☐ No
2. The staff demonstrated open, professional behavior. ☐ Yes ☐ No
3. The staff demonstrated competence in meeting patient care needs. ☐ Yes ☐ No
4. The student orientation to hospital and patient care area was effective. ☐ Yes ☐ No
5. The unit operations were organized. ☐ Yes ☐ No
6. The unit manager was available when needed. ☐ Yes ☐ No

7. What resources at our hospital were helpful in meeting your goals?

8. What additional resources may have augmented the student experiences?

9. Recommendations to improve clinical experiences:

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Staff Evaluation of Clinical Experiences

Date: _____ Unit: _____

School: _____ Semester: _____

We want to thank you for your time and efforts in working with students during their clinical rotation here at _____ Hospital. Knowing that the students of today will be the expert caregiver of tomorrow, we hope you appreciate the importance of your input into their clinical growth and development. We are interested in your comments and feedback about your experiences with the students on your unit. Please take a few minutes to complete the following questionnaire and return it to the Clinical Placement Coordinator in the facility you are utilizing. Your feedback is important to us. **Thank you!**

1. Were the students able to articulate their learning needs? ☐ Yes ☐ No
Comments:

2. Were the students adequately prepared for clinical activities/responsibilities? ☐ Yes ☐ No
Comments:

3. Did the faculty provide you with information regarding student competencies? ☐ Yes ☐ No
Comments:

4. Was faculty available to student/staff when needed? ☐ Yes ☐ No
Comments:

5. Did students display initiative and professionalism during clinical experience? ☐ Yes ☐ No
Comments:

6. Recommendations to improve clinical experiences for students and staff:

7. Other comments:

MedStar Health

Student Evaluation of Clinical Experiences

We want to thank you for your time and efforts in providing care to our patients during your clinical rotation. We hope this experience exceeded your expectations and provided you with a great learning experience. We are interested in your comments and feedback about your rotation here. Please take a few minutes and complete the following questionnaire. Your feedback is important to us. **Thank You!**

School: _____ Semester and Year: _____

Hospital: MFSH____ MGSH___ MHH ____ MUMH ____

UNIT: _____ SHIFT: _____

Please evaluate the individual unit to which you were assigned with regard to the following criteria using a check (√) in the box that reflects your opinion of this rotation.	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
Factors	**1**	**2**	**3**	**4**	**5**
Unit operations were organized. **Comments:**					
Resources were readily available. **Comments:**					
Personnel were friendly. **Comments:**					
Personnel were eager to assist. **Comments:**					
The experience obtained was beneficial to my education. **Comments:**					
Level of patient care required was appropriate to my level of ability. **Comments:**					

Would you consider this institution as a future employer? ____ Yes ____ No

If no, please explain: _____

MedStar Health

MedStar Health Clinical Placement Coordinators

Medstar Union Memorial:

Corinne M. Weigand, MA
Nursing Staff Development Specialist
MedStar Good Samaritan Hospital
5601 Loch Raven Boulevard
Baltimore, MD 21239
P 443-444-4705
corinne.m.weigand@medstar.net

Lola Kropkowski, MSN, RN, NPD-BC
Nursing Professional Development Specialist
MedStar Union Memorial Hospital
201 E University Parkway
Baltimore, MD 21218
P 410-554-2493
Lola.kropkowski@medstar.net

MedStar Good Samaritan Hospital:

Corinne M. Weigand, MA
Nursing Staff Development Specialist
MedStar Good Samaritan Hospital
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