



MedStar Health

**ORIENTATION  
FOR  
NURSING FACULTY**  
at  
MedStar Good Samaritan Hospital  
&  
MedStar Union Memorial Hospital  
**PART IV**

**2019-2020**

Revised July 2019  
JAB

# **Clinical Instructor Forms**

**All the following forms are to be  
completed and turned into the Clinical  
Placement Coordinator  
on 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.

Both 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 Orientation Manual and the Faculty Manual for each Nursing Faculty.

Each the following required documents must be completed and signed by the clinical instructor and turned into the Department of Education on or before the first clinical day.

- Documentation Summary
- Course Objectives
- Clinical Instructor's CV/Resume
- Faculty Information Sheet
- Instructor and Students' Confidentiality Statement
- Safety, TJC, Infection Control-Signature Sheet
- Medication Administration Patient Identification Signature Sheet for Instructors
- MedStar Code of Conduct Attestation Form
- Student Roster
- Background Check & Drug Screen Verification
- Verification of Flu Vaccine
- Medconnect Access Requests for Students
- Medconnect/Pyxis Access Requests for Instructors

Clinical instructors who do not complete the required documentation on the first day of the clinical rotation will not be permitted to participate in the clinical experience.

All documentation may be dropped off at my office on the fourth floor, Sleep Lab or dropped in my mailbox located in the Nursing Office on the third floor off the main elevators.

Sincerely,

*Joy*

Joy Burke RN, MSN, CCRN  
Education Specialist/Staff Development  
443-444-5790  
[joy.burke@medstar.net](mailto:joy.burke@medstar.net)

**All boxes  
must be**



MedStar Health

Documentation Summary

Name of School: \_\_\_\_\_

Instructor's Signature: \_\_\_\_\_

Instructor's Initials \_\_\_\_\_

Complete and submit all forms before the 1<sup>st</sup> clinical day

Revised 7/13

<b>Document</b>	<b>Date</b>	<b>Instructor's Initials</b>
<b>Course Objectives</b>		
<b>Current instructor resume on file at hospital</b>		
<b>Faculty Information Sheet</b>		
<b>Instructor and Students' Confidentiality Statement</b>		
<b>MedStar User Confidentiality Agreement Signature Sheet</b>		
<b>Safety, TJC, Infection Control Signature Sheet</b>		
<b>Medication Administration Patient Identification Signature Sheet for Instructors</b>		
<b>MedStar Code of Conduct Attestation Forms</b>		
<b>Students' Roster</b>		
<b>Background Check &amp; Drug Screen verification submitted to clinical placement coordinator</b>	<b>Completed and emailed by school</b>	
Instructor Cerner/MedConnect Training		
Instructor's Orientation to Facility & Unit		
Instructor's Computer Access Code		
HIPAA Training	<b>On file at school</b>	
Instructor's CPR Card	<b>On file at school</b>	
Instructor's Health Screening	<b>On file at school</b>	
Instructor's Flu Vaccine Record for Current Year	<b>On file at school</b>	
Instructor's License	<b>On file at school</b>	
Instructor's Mandatory Training (Blood borne Pathogens, etc.)	<b>On file at school</b>	
Students' CPR Card	<b>On file at school</b>	
Students' Health Screening – specifics p12	<b>On file at school</b>	
Students Flu Vaccine Record for Current Year	<b>On file at school</b>	
Students' Mandatory Training/HIPPA	<b>On file at school</b>	
Students' RN License (RN-BSN or Master's Student)	<b>On file at school</b>	



**MedStar Health**

***Faculty Information***

**Clinical Instructor's Name**

---

**Name of School**

---

**email Address**

---

**Home Phone Number**

---

**Cell Phone Number**

---

**Office Phone Number**

---

**Additional Information**

---



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 \_\_\_\_\_

Print Name (Instructor) \_\_\_\_\_ Signature/Date \_\_\_\_\_

School Name \_\_\_\_\_



## **User 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 foster's 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**

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 \_\_\_\_\_

Print Name \_\_\_\_\_ Signature/Date \_\_\_\_\_

**(Instructor)**

School Name \_\_\_\_\_



# MedStar Health

## Safety, Joint Commission, Infection Control Signature Sheet

School/Agency: \_\_\_\_\_

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

Name (Please Print)	Signature	Date
Instructor		



**To: All Nursing Instructors**

**Re: Medication Administration / Patient Identification Signature Sheet**

Thank you for choosing MedStar for your clinical rotation. We know you have a choice in where you teach your clinical rotations, and we're pleased that you've chosen to share your time, talent and expertise with your students here.

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.

---

Signature of Nursing Instructor

Date

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

All MedStar Nursing Policies may be found online on the StarPort page  
Please ask for assistance if you have any problems accessing this information.





# MedStar Health *Student Roster*

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

Name of School: \_\_\_\_\_

Instructor: \_\_\_\_\_

Instructor Phone Number (Home) \_\_\_\_\_

(Work): \_\_\_\_\_

Clinical Unit: \_\_\_\_\_

Days: \_\_\_\_\_

Hours: \_\_\_\_\_

E-mail: \_\_\_\_\_

Dates: \_\_\_\_\_

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



MedStar Health

## **Vaccination Requirements**

**PPD**-Evidence of a negative tuberculin skin test by Mantoux PPD within the twelve (12) months prior to the start date (must be updated annually)

If student has not had a PPD test in the previous twelve (12) months, evidence of a negative two-step PPD is required;

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. Student is then required to complete an annual questionnaire to identify symptoms of tuberculosis

Proof of immunity to **Measles, Mumps and German Measles** (Rubella) by providing documentation of two (2) MMR vaccines; or two (2) measles, one(1); or rubella and one mumps; or laboratory evidence of immunity. (Persons born before 1957 require documentation of one (1) MMR vaccine

Evidence of a positive history of chicken pox (**varicella**) disease, laboratory evidence of immunity, or documentation of immunization with two (2) doses of chickenpox vaccine.

Documentation of completion of **Hepatitis B**, or if the individual declines the vaccine, a signed statement of declination.

Evidence of **flu vaccine** within specified date

## **Physical Examination**

A normal physical examination performed once prior to start date as long as the student in continuously enrolled in the program. Components of the physical should include examination of the head, eyes, ears, nose, throat, heart, lungs, abdomen, neurological and musculoskeletal systems.



MedStar Health

## Faculty Medconnect Verification Form

I have taken the MedStar Medconnect II training class.

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

\*If you do not have access to the Medconnect System. You **must** complete a course offered at one of the MedStar Hospitals prior beginning your Clinical Rotation. To obtain a listing of the available classes, please contact the Clinical Placement Coordinator.



## 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 D.
2. A criminal background check covering the prior seven (7) years was completed on (enter date on spreadsheet). 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 spreadsheet) and the results are negative.

.....

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



## 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	Criminal Background Check Date	Negative Nine (9) 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 Entity upon request.

\_\_\_\_\_  
(Signature of College Representative) Date





MedStar Health

***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:

10. Other comments:

## 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:



### 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\_\_\_ MGSB\_\_\_ MHH \_\_\_ MUMH \_\_\_

UNIT: \_\_\_\_\_ SHIFT: \_\_\_\_\_

<i>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.</i>					
	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Factors	1	2	3	4	5
Unit operations were organized. <b>Comments:</b>					
Resources were readily available. <b>Comments:</b>					
Personnel were friendly. <b>Comments:</b>					
Personnel were eager to assist. <b>Comments:</b>					
The experience obtained was beneficial to my education. <b>Comments:</b>					
Level of patient care required was appropriate to my level of ability.  <b>Comments:</b>					

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

*If no, please explain:*

---

**MedStar Health  
Clinical Placement Coordinators**

**1. MedStar Franklin Square Medical Center:**

**Thomas Maykrantz RN  
Clinical Specialist  
MedStar Franklin Square Hospital  
9000 Franklin Square Drive  
Baltimore, Maryland 21237  
443-777-7006  
Email: [Thomas.O.Maykrantz@medstar.net](mailto:Thomas.O.Maykrantz@medstar.net)**

**2. MedStar Good Samaritan Hospital:**

**Joy Burke, MSN, RN-BC  
Education Specialist  
MedStar Good Samaritan Hospital  
5601 Loch Raven Boulevard  
Baltimore, MD 21239  
Phone: 443-444-5790  
Fax: 443-444-4250  
Email: [joy.burke@medstar.net](mailto:joy.burke@medstar.net)**

**3. MedStar Harbor Hospital Center:**

**Denise Schreiner, MSN, RN, CCRN, NEA-BC  
Service Excellence Coordinator  
Patient Representative  
Clinical Placement Coordinator  
Medstar Harbor Hospital  
3001 South Hanover Street  
Baltimore, MD 21225  
Phone: 410- 350-3487  
Fax: 410-350-3484  
E-mail: [denise.schreiner@medstar.net](mailto:denise.schreiner@medstar.net)**

**4. MedStar Union Memorial Hospital:**

**Joy Burke, MSN, RN-BC  
Education Specialist  
Clinical Placement Coordinator  
MedStar Union Memorial Hospital  
201 E. University Parkway  
Phone: 443-444-5790  
Fax: 443-444-4250  
Email: [joy.burke@medstar.net](mailto:joy.burke@medstar.net)**