☐ Observer ☐ Shadow ☐ Clinical Rotation ☐ Post Secondary Internship ☐Health Occ Student High School (For office use only)

UP HEALTH SYSTEM MARQUETTE STUDENT QUESTIONNAIRE

PLEASE PRINT CLEARLY

NAME (legal name): (F) _____ (M) _____ (L) _____

NICKNAME (optional): _____ (this what will appear on your badge for others to call you by)

SOCIAL SECURITY NUMBER _____-_____-_____ (must be full social)

MARITAL STATUS (S, M, D, W) _____

BIRTHDATE _____-_____-_____

GENDER _____

ADDRESS _____

CITY, STATE, ZIP CODE _____

*note this can be either a local school address or a home address

PHONE (Cell # preferred) _____

EMAIL ADDRESS _____

START DATE----END DATE _____-_____

EDUCATIONAL PROGRAM _____

SCHOOL AFFILIATION _____

_____ I will practice within the scope of my role as a student as described by my school or university to ensure patients, families, visitors, and staff safety.

Have you ever worked, volunteered, or been a student at UPHS? _____Yes _____ No

If yes, which one. _____Employee _____Volunteer _____ Student _____ Other

UPHS MARQUETTE - Liability Disclaimer and Confidentiality Pledge

I, (print name) _____, and affiliate of _____ (institution), do acknowledge that UPHS Marquette is providing me with the opportunity to:

- Observe with a designated preceptor
- Shadow with a designated preceptor
- Participate in Clinical Activities with a designated preceptor

Effective: _____ (start of rotation)

By providing me with this opportunity, neither UPHS Marquette, nor any of its employees, will document completion of a training program, or document my individual competence. I recognize and acknowledge that this is an opportunity for me to learn and that the responsibility for this knowledge and/ or competence to perform various tasks is my own. I understand I will be in compliance with UP Health System Marquette 100-108, "Training/ Observation/ Education of Persons Not Employed by UPHSM."

I will indemnify and hold harmless UPHS Marquette from and against any person injury, death or property damage caused directly or indirectly by any act or omission of any person while involved in the performance of duties or while within the premises pursuant to this agreement.

I understand that information about the hospital patients is confidential according to Federal and State law and may not be disclosed without the specific written consent of the patient. I further understand that UPHS Marquette has allowed me to observe certain procedures for educational purposes on the condition that I will preserve the patient's rights to confidentiality by refusing to give out any patient information to any person. I understand that I will not represent myself as an employee of UPHS Marquette and will not allow patients to consent/ refuse to any procedure in which I am involved.

I understand the dress code component of this visit and will abide by the guidelines set forth by the areas of the hospital departments where I will be located based on the areas identified above.

I understand that I am not to actively participate in any procedure that is beyond my level of training, licensure, or scope of practice.

I agree that I have read, reviewed, and understand the attached materials. I understand it is my responsibility to seek clarification from the UPHS Marquette Educator on any issues which remain unclear or unanswered.

I fully recognize the hazards in health-related professions and hereby hold UPHS Marquette harmless from any liability from my voluntary decision to be vaccinated or to decline to be vaccinated.

_____ _____

Signature Date