STUDENT PASSPORT FORMS

Student Information Sheet
Welcome Test Student Answer Sheet
Health History
TB Form
Parkview Student ID Instructions
Parkview Health Confidentiality

Required Reading & Video References:
Welcome to Parkview Health
Epic Training
PRMC Education

INSTRUCTIONS:

Complete all sections of the Student Passport.

The Student Passport should be submitted during a student’s first semester and/or rotation at Parkview. Additional Passports are only needed if the student changes schools or begins a new program. Passports can be submitted via email to students@parkview.com or fax to (260) 373-3168.

Student Services should receive completed forms a minimum of two weeks prior to the scheduled start date.

Revised July 2018
# Parkview Health Student Passport
## Student Information Sheet

**Full Name (please print)** | **Date of Birth**
---|---

**Phone** | **Last Four Digits of Social Security Number**
---|---

**School Email (only.edu address here)** | **Previously assigned Parkview Student or Employee ID# (if applicable)**
---|---

**Home Address**

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*All information on this form will be kept in a secure, private location and used only in the event of an emergency or urgent business-related situation. If student does not have a social security number, please provide the last 4 numbers of the student's international Visa number.*

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**School Name** | **Program Enrolled**
---|---

**School Coordinator/Instructor Name & Contact**

**Clinical Course(s)**

________________________ (insert semester & year on line, i.e. Spring 2018)

Clinical Start Date(mm/dd/yy)___________________    Clinical End Date(mm/dd/yy)__________________

**Total internship hours needed** | **Total Hours Per Week:**
---|---

**Day(s) of week (Please circle)**

<table>
<thead>
<tr>
<th>Sun</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thurs</th>
<th>Fri</th>
<th>Sat</th>
</tr>
</thead>
</table>

**Time(s) of Day Available**

**Parkview location(s) desired**

If you listed PPG offices, specify which state

□ Indiana  □ Ohio

**Department Desired**

**Student Signature**
Parkview Health
Student Test Answer Sheet

Please record your answers here for the Parkview Student Test found in the Required Reading: Welcome to Parkview.

1.) 2.) 3.) 4.) 5.) 6.) 7.) 8.)
Health History

Print name:

Last          First          Middle

Date of birth:            Telephone number:            School Email Address:

________________________________________  ___________________________  ___________________________
(MM/DD/YYYY)

Home address:

Street          City          State          Zip Code

________________________________________

College/University/School you are attending:  ______________________________________________________

*If you have current health vaccination history on file at your school, please check the box to the right and sign below.

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Student Signature          School/Department          Date

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*If you do not have current health vaccination history on file at your school, please complete the below information.

HEALTH VACCINATION HISTORY
The following are REQUIRED VACCINATIONS for students in direct patient care areas:

Measles/Mumps/Rubella vaccine: Date #1 _____ Date: #2_______

Did you have the chickenpox? Y or N

Chicken Pox (Varicella) vaccine: Date #1 _____ Date #2 _______ Titer (date drawn): _____________

Tetanus or Tetanus Diphtheria: Date: _____________  Polio Vaccine Date: ________________

Hepatitis B Vaccine: Date: #1__________ #2_________ #3_________ Titer (date drawn): _____________

or initial the following statement:

I understand that I will be at risk of accidental exposure to blood and/or body fluids and therefore the risk of Hepatitis B, a serious disease. Hepatitis B vaccine protection prior to this experience has been recommended to me. Initials: [_______]

*Student/School Must Provide Upon Request
TB Form

TB (Tuberculosis) TEST

Will your learning experience take place partially or entirely at Parkview Randallia or Parkview LaGrange?
  □ YES - a TB Test is REQUIRED for these sites.  □ NO – a TB Test is optional

TB Test (Mantoux, PPD, or TST) (within last 12 mo.)  Date___________ Please attach copy of TB test results.

If positive reactor, a Chest X-ray is required.

Date___________ Please attach copy of X-ray results.

TB Skin Tests can be obtained at area Parkview Occupational Health Centers, other urgent care centers, clinics, or private physician offices for a cost of approximately $20-25. Parkview does not cover this expense for students or observers at our facilities. Please present this form to the agency when obtaining a TB Test. A return visit to the agency is required 48-72 hours after the TB skin test is administered to have the results read

I hereby affirm that the health vaccination history and TB test information given on this form is accurate and complete.

Signature: ___________________________________________  Date: _________________
PARKVIEW HEALTH
CONFIDENTIALITY AGREEMENT

I understand that in the performance of my duties as an affiliating student or faculty member of affiliating school that during my participation in the clinical education program at Parkview Health System, Inc. ("Facility") I may have access to and may be involved in the processing of verbal, written, computer generated, computer accessed, filmed, and/or recorded information related to patients, physicians, employees and business information, all identified as “Confidential Information”, as defined by the Parkview Health Confidentiality Policy. I understand that I am required to protect and maintain the confidentiality of this Confidential Information at all times.

I acknowledge that if my position requires application of an electronic signature code, it is the equivalent of my legal handwritten signature. I understand that if I disregard the confidentiality of my electronic signature code, use the code of another person, or fail to comply with these confidentiality requirements, I will be committing an illegal and/or unprofessional act.

I understand that a violation of these confidentiality considerations may result in disciplinary action, up to and including termination of my participation in the clinical education program at Facility or legal action.

I certify by my signature that I have knowledge of the provisions of the Parkview Health Confidentiality Policy. I agree to adhere to and uphold Parkview Confidential Information.

Name: ____________________________________________

(please print)

Signature: _________________________________________  Date: ________________

Email Address: ____________________________________
Parkview Student ID Instructions
(Keep for your records)

Parkview students may access training and associated applications through NetLearning.

Parkview Student ID numbers and passwords will be shared with a student’s designated school representative or Parkview leader overseeing the student experience. Students should obtain ID number.

How to Work in NetLearning

2. Username: Enter your 6-digit Parkview ID (for example 199999)
3. Password: If you have never logged into the Parkview NetLearning program your password is “parkview” - all lower case with no quote marks.
   - If you are a returning Parkview student with previous login history (and existing private password), your password is the same existing password.
   - Use the main Menu/My profile section to add an email address. This will allow the system to send you an email if you have forgotten your password. You can also reset your password here.

4. Search for the CBL Safeguarding Non Electronic PHI in the CBL’s widget.

5. Click on the CBL to review the course material.

6. Make sure to take the test and save to record your completion.

To see your Transcript, click “Report” then “Transcript” (select dates at top). This shows your record of completed CBL’s and classes in alphabetical order. For assistance please contact IS Service Center Help Desk at (260) 266-8500, option 4.