St. Rose Student Packet:

1. Student Registry Checklist
    a. Student Name, etc.
    b. School contract on file in Program Office
    c. Certificate of Liability on file in Program Office
    d. Name of instructor
    e. Completion of "Reorientation" Module to be completed later
2. New Student Requirements
3. Copy of student immunizations **(Program Office will attach)**
4. ITS Authorization Request
5. BLS **(Program Office will attach)**
6. N95 Mask Fit Test **(Program Office will attach)**
7. Background/Drug Screen Letter **(Program Office will attach)**
8. HealthStream Certificate Transcript **(Program Office will attach)**

St. Rose HOSPITAL

DATE: _____

STUDENT NAME: _____

PHONE NO: _____

SCHOOL: _____

DEPARTMENT: _____

DATES: _____

TOTAL HOURS: _____

STUDENT/INTERNSHIP or EXTERNSHIP, CLINICAL ROTATIONS, PRECEPTORSHIP, RESIDENCY, and REGISTRY CHECKLIST

☐ Current School Contract on file in Education and Training.

☐ Current valid Certificate of Liability Insurance from school and or evidence that the student has obtained Malpractice Insurance on file in Education and Training.

☐ Name and phone number of Emergency Contact Person at school:

Instructor's Name:_____ Instructor Phone #:_____

☐ Copy of the student's current BLS/CPR card from American Heart Association.

☐ Medical Requirements: **(To be "Cleared by Employee Health Nurse")**

1) TB Skin Test (TST)
2) Measles (Rubeola)
3) Mumps
4) Rubella
5) Varicella
6) Hep-B
7) Tdap
8) Fit-Test
9) Influenza Vaccine

Please see separate attachment.

Students working with **"patients"** will need a Respirator Fit Test. Must be N95 3M 1860 or 1870; Moldex 1517, within 1 year.

☐ Current background check letter stating "no abuse", "no fraud" and "no felonies" on file.

☐ Completion of St. Rose Hospital "Reorientation" module and completion of the HIPAA Privacy, Confidentiality and Security Training packet prior to start date. (Please contact Education & Training at 510-264-4044 or email: jnolasco@srhca.org)

St. Rose HOSPITAL

NEW STUDENT REQUIREMENTS

NAME: _____ DATE: _____

DEPT: _____ TITLE: _____

TBD	TST - TB TEST
	History of Negative (-) TB Test Test 1: _____ mm Date: _____ Test 2: _____ mm Date: _____ **TB testing no greater than 12 months from start date**
	History of Positive (+) TB Test Positive skin test: _____ mm Date: _____ **Chest x-ray report: Required (no greater than 12 months from start date)** TB Symptom Review Completed Date: _____
	MEASLES (RUBEOLA) - Proof of 2 vaccinations or positive titer Date Dose 1: _____ Titer Neg / Pos Date Dose 2: _____ Date: _____
	MUMPS - Proof of 2 vaccinations or positive titer Date Dose 1: _____ Titer Neg / Pos Date Dose 2: _____ Date: _____
	RUBELLA - Proof of 2 vaccinations or positive titer Date Dose 1: _____ Titer Neg / Pos Date Dose 2: _____ Date: _____
	VARICELLA - Proof of 2 vaccinations or positive titer Date Dose 1: _____ Titer Neg / Pos Date Dose 2: _____ Date: _____
	HEPATITIS B - Proof of 3 doses & Positive Titer Date Dose 1: _____ Titer Neg / Pos Date Dose 2: _____ Date: _____ Date Dose 3: _____
	TDAP Within 10 years Date of Vaccine: _____
	N95 RESPIRATOR FIT TESTING Date: _____ **3M 1860 SM** ☐ **3M 1860 REG** ☐ **3M 1870+ ONE SIZE** ☐ **MOLDEX 1517 ONE SIZE** ☐
	INFLUENZA VACCINE From October to April of the following year Date of Vaccine: _____

Approved by Employee Health Services: _____ Date: _____

ST ROSE HOSPITAL
INFORMATION TECHNOLOGY SYSTEMS AUTHORIZATION REQUEST
FOR TEMPORARY AND CONTRACTOR STAFF AT ST. ROSE

This form is used for temporary staff and consultants (non employees) that are working with St. Rose Hospital. It is not to be used for system access by Physician office staff.

- Use this form to notify the IT Help Desk of Adds, Changes and Deletes
- Initiate a Help Desk Ticket and attach this completed form as your authorization.
- Note special instructions and/or requests in Comment Section of your ticket.

Please note:

Access to our systems will be provided in ***six month increments*** and requires confirmation from a St Rose Manager if the non-employee continues to have a business need to extend their access an additional amount of time.

Password requirements:

Passwords **MUST** contain at least eight characters, with a combination of at least three of the following four character types:

- Upper case letters (A – Z)
- Lower case letters (a – z)
- Numbers (0 – 9)
- Special characters (! @ # $ %)

Passwords cannot be part of your name, or User ID. Passwords expire every 90 days. The system remembers your last five passwords.

For your protection, password resets can only be requested by you, and must be done via a phone call to the Help Desk at (510) 264-4036.Another person cannot make this request on your behalf.

Employee Type _____ Status _____ Effective Date * _____

EEID _____ SSN * XXX-XX-_____ Date of Birth _____

Last Name * _____ First Name * _____ Middle _____

Calling Name _____ Gender _____ Marital Status _____

Race _____ Ethnicity _____ Job * _____

Department * _____ Additional Access * _____
(i.e., File CD, PACs, etc.)

Users Signature* : _____ Date *: _____

Requesting Manager * : _____ Date *: _____

Help Desk Notes: Access will expire every June 30th and Dec 31st.To guarantee continuous access, please call St. Rose Hospital's IT Help Desk at 510-264-4036 before the expiration dates.