



Attestation Form for Clinical Rotations

School: _____

CCPS Approval Date: _____

Program: RN ___ BSN ___ LPN ___ CNA ___ PT ___ RT ___ CRNA ___ EMT ___ Dietary ___ Surg.Tech ___ PA ___ Other ___

Program Director: _____

Telephone: _____

Email: _____

Fax: _____

Rotation Dates: Start Date: _____ Completion Date: _____ Times: _____

DAYS OF WEEK: M ___ Tu ___ Wed ___ Th ___ F ___ Sat ___ Sun ___

Course #: _____

Instructor's Name: _____

Instructor's Phone: _____

Instructor's Email: _____

Instructor completed Orientation: Yes ___ No ___ Instructor has PWH ID Badge: Yes ___ No ___

*****All Instructors must have PWH ID Badge PRIOR to clinical rotation*****

Unit Requested: _____

Specialty: _____

Number of Students: _____ Please Type or Print Name & Telephone # of Students:



****All requirements MUST be met prior to the start of each rotation****

Physical Examination Completed on Students YES___ NO___

Criminal Back Ground Check Completed on Students YES___ NO___

Required Immunizations Completed on Students YES___ NO___

Seasonal Influenza Vaccine (10/1-3/31 only) N/A___ YES___ NO___

Drug Tests Completed on Students YES___ NO___

Students have current CPR cards YES___ NO___

Signed Confidentiality & Security Agreement Form (From PWH Website) YES___ NO___

Signed HIPAA Privacy/Security Validation Form (From PWH Website) YES___ NO___

Signed Affirmation of Completing Orientation Form (From PWH Website) YES___ NO___

As a designated representative of the school affiliation named above, I attest that the above information has been reviewed and approved, and is **maintained in each student/instructor's file at their facility**, and that each affiliation representative has been determined to be assigned appropriately for clinical rotation at Palms West Hospital. I agree that should any student/instructor fail to maintain the standards or fail to uphold the policies of Palms West Hospital, his/her immediate removal, and when necessary replacement, shall take place.

Program Director (Please Print)

Program Director (Signature)

School Affiliation

Date

Palms West Hospital will conduct annual audits for information listed above

Palms West Hospital – Education Department

Received: Date and Time

Approved By:

6/2014