

John H. Stroger, Jr. Hospital of Cook County

Cook County Health & Hospital System

(formerly Cook County Bureau of Health Services)



Toni Preckwinkle

President

Cook County Board of Commissioners

William T. Foley

CEO

Cook County Health & Hospital System

Warren L. Batts

Chairman

Cook County Health & Hospital System

Anthony J. Tedeschi, MD, MPH, MBA

COO

John H. Stroger Hospital

John M. O'Brien, M.D.

PER Chairman

John H. Stroger Hospital

Department of Planning, Education and Research

627 S. Wood Chicago, #832

Illinois 60612

(312) 864-0394

Summary of Requirements on the New Certificate of Compliance Health Form

- Stroger Hospital has instituted a new certificate of compliance health form. Beginning September 1, 2004, all students must meet the new requirements before starting a rotation at Stroger.
- A two-step tuberculin skin test (TST), QuantiFERON-Gold (QTF-G), or evidence of annual TST's is now required. It will take a minimum of 10 days to complete the two-step testing. Place the first test and read 48 – 72 hours later. One to three weeks after placement of a negative first test, place the 2nd test. Read 48 – 72 hours later.
- For those with a positive TST step one or two, a chest x-ray is required within one year of start date at Stroger, or at the time a positive skin test was documented by an affiliated institution.
- Regardless of immunization status, titers are required for measles, mumps, rubella, varicella and Hepatitis B.
- Measles and rubella immunity is required.
- Hepatitis B surface antigen is required only when Hepatitis B surface antibody is negative.
- Please note that *laboratory results must be attached* to the certificate of compliance health form.

Click below to obtain the Health Form. It is also available on our website under the heading: "Infection Control Form"

<http://medicine.johnstrogerhospital.org/per/Infection%20Control%20Form/ic%20ehs%20purple%20form%205.25.10.doc>

John H. Stroger, Jr. Hospital of Cook County

Cook County Health & Hospital System

(formerly Cook County Bureau of Health Services)

Name: _____

Address: _____

_____ Phone: _____

E-Mail Address: _____

School: _____

Address: _____

_____ Phone: _____

Supervisor: _____

E-Mail Address: _____

Indicate your objectives for this experience. What are you expected to do (observe, participate in patient care, interview employees, etc)?

JSH APPROVAL:

Department Head

Date

Approved

Denied

Chair, Department of PER

Date

SENDING INSTITUTION'S APPROVAL:

The requested clinical experience is related to and is a required part of the student's educational program. Basic preparation for this experience has been provided the student through classroom instruction and laboratory practice.

Signature of Dean/Department Head

Date

John H. Stroger, Jr. Hospital of Cook County

Cook County Health & Hospital System

(formerly Cook County Bureau of Health Services)

HEALTH PROFESSIONS STUDENT INDIVIDUAL AGREEMENT FOR LIMITED CLINICAL OBSERVATION/TRAINING

I _____ (“Student”), hereby represent that, in consideration of being granted permission to observe and, if authorized by the applicable Hospital Supervisor, to participate in supervised patient care at Stroger Hospital of Cook County (“Hospital”), located at 1901 West Harrison Street, Chicago, Illinois, hereby agree to the following terms and provide the following information, understanding that the County and its Hospital are relying upon such information and upon such agreement:

1. ***Date of Birth and Residence.*** My date of birth and current residence are as follows:

2. ***School/Program Affiliation.*** I am a current student in good standing at the following school and am enrolled in an accredited educational program in a health profession as follows:

_____ at _____

Health Care Discipline

College Name and Address

3. ***Assignment.*** I request permission to observe the provision of health care to patients at Hospital in the _____ department on _____ (dates) and to participate in supervised patient care activities upon being expressly instructed to do so by my Hospital supervisor.

4. ***Student Supervision.*** I understand that I have status of trainee and may render patient care or other services only under direct supervision and as directed by my Hospital supervisor, an individual who shall be designated by the head of the department listed in paragraph (3) above. I agree to abide by all Hospital policies and procedures while on site at the Hospital. I understand and agree that the Hospital retains full authority and responsibility for patient care at the Hospital and that either the department head or my Hospital supervisor may at any time terminate my participation in Hospital activities.

5. ***Identification.*** While on the Hospital premises, I shall at all times exhibit an appropriate identification badge furnished by the Hospital which I shall return to the Hospital at the conclusion of the assignment. I shall identify myself to Hospital patients and staff in accordance with Hospital procedures.

6. ***Health Requirements:*** I have provided the following documentation to the Hospital’s Department of Planning, Education and Research Office prior to my participation in activities at Hospital:

- 1) Proof that I received the Hepatitis B Vaccination and other vaccinations that may be required by the Hospital;
- 2) Proof of Tuberculosis (TB) screening within one year of my participation in activities at Hospital.

Further, I represent that I am in a condition of health which enables me to participate safely in patient care activities at the Hospital, subject to the following limitations:

7.. ***Emergency Medical Care.*** I give my permission for the Hospital to provide emergency medical care and treatment in the event of injury and illness occurring at the Hospital. I understand that I am responsible for the expense associated with such treatment.

John H. Stroger, Jr. Hospital of Cook County

Cook County Health & Hospital System

(formerly Cook County Bureau of Health Services)

8. **Confidentiality.** I acknowledge that all Hospital patient information is absolutely confidential and shall not disclose directly, indirectly, or by implication, or use such information in any way at any time, except solely as required to perform assigned tasks at the Hospital.
9. **Professional Liability Insurance.** If requested by the Hospital, I have provided the Department of Education and Training with proof that I am covered by insurance which insures against professional liability I may incur while participating in patient care activities at the Hospital.
10. **Volunteer Status.** I understand that I will be paid no compensation by the County with respect to my activities at the Hospital and that I am neither an employee of the County nor am I entitled to any benefit to which County employees may be entitled such as, but not limited to, compensation, retirement or disability benefits, workers' compensation benefits or any other benefits.
11. **Governing Law.** This Agreement shall be interpreted under and governed by the laws of the State of Illinois. Venue shall lie in a court of competent jurisdiction located within the County of Cook, Illinois.

Signed by Student:

Printed Name

Date

Acceptance by Hospital:

Department of Planning, Education and Research

Date

Acceptance by Clinical Supervisor at Hospital:

Department Chair

Date