

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

Thank you for your interest in student rotation. Rotations may be available to qualified students based on current agreements with your school.

To apply for a rotation, you must submit a completed application form, signed by the dean or the department head. The school seal must be affixed. **UIC students are not required to complete and application form**

If accepted, you must present documentation of the following:

- Infection control requirements (successfully pass the module on our website)
- Health requirements – Please complete the Certificate of Compliance Health Form and bring it with you along with the supporting lab work. Please see attached handouts for details.
- Proof of Professional Liability Insurance
- Proof of a Criminal Background Check in the U.S.

The college will provide this documentation on the students behalf.

We need at least four weeks to process an application.

Please feel free to call our office at 312/864-0431 if you have questions.

Sincerely,

Luann Jointer

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TO: Residency Program Directors
Medical School Deans
Directors and Nursing Allied Health Programs

FROM: John O'Brien, M.D.
Chairman, Planning, Education, and Research

RE: ORIENTATION REQUIREMENTS FOR STUDENTS AND ROTATORS PRIOR TO STARTING A ROTATION AT JOHN STROGER HOSPITAL

All rotating physicians and students must be educated annually regarding their risk of exposure to bloodborne and airborne pathogens and appropriate precautions to reduce these risks (also known as BSIS education, Body Substance Isolation system). In addition, all first-time trainees must successfully complete and on-line orientation module.

BSIS/Infection Control

[refer to the training link on the 'required forms' page.](#)

Residents and students rotating to Stroger Hospital are required to annually demonstrate satisfactory knowledge and understanding of the BSIS principles prior to starting a rotation at our institution. This can be accomplished most easily by reviewing the teaching/learning module posted on our website (www.cookcountyhospital.edu). Alternatively, a trainee may choose to attend a BSIS educational session. These are conducted by the Department of Planning, Education and Research each Monday and Wednesday morning, from 8:30 a.m. to 10:00 a.m. Interested individuals should report to Room 815 in the Hektoen Building, 627 S. Wood St., 8th floor. No one will be authorized to start a rotation without successful completion within the past one year.

Stroger Orientation

[refer to the training link on the 'required forms' page.](#)

All trainees are required to annually review an orientation module that covers topics ranging from hospital safety to pain recognition and management. This is designed to familiarize incoming students and providers with our hospital and some of the important policies and procedures. The orientation module is also found on-line at our website.

If you have any questions, please feel free to call Ms. Luann Jointer at 312/864-0431. You may also email her at ljointer2@ccbhs.org.

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PROFESSIONAL LIABILITY INSURANCE REQUIREMENTS

The College will provide this documentation on the students behalf.

The following professional liability insurance requirements must be submitted as part of your application for an elective rotation at Stroger Hospital:

- We require a **Certificate of Insurance** indicating the coverage to be in effect. Do not submit a copy of the insurance policy itself.
- The Certificate of Insurance must state that the insurance in effect will not be canceled or modified without thirty (30) days prior notice to Stroger Hospital.
- Minimum amounts of coverage are one million dollars per occurrence, and three million dollars aggregate.

Your application will not be considered approved until the above requirements are met, therefore please include the certificate with your application.

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Summary of Requirements on the New Certificate of Compliance Health Form

The College will provide this documentation on the students behalf.

- 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>

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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

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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.

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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