COOK COUNTY HEALTH (CCH) SUMMARY OF REQUIREMENTS CERTIFICATE OF COMPLIANCE HEALTH FORM-PROFESSIONAL EDUCATION

Last Name **First Name** **DOB**

Program/School **Start Date**

Below you will find the CCH health requirements. All students must meet the requirements listed before starting a rotation at Stroger. Annual updates are required.

- **Tuberculosis Screening**- Initially you will need to provide the results of a *Interferon Gamma Release Assay (*often the Quantiferon- Gold is used) done within the last 3 months, and annually complete the *Tuberculosis Surveillance Questionnaire* (below).
- **Vaccinations**:
  - **Measles** - Documentation of 2 MMRs vaccines* or titers demonstrating immunity to measles
  - **Rubella** - Documentation of 1 MMR vaccine* or titers demonstrating immunity to rubella
  - **Mumps** - Documentation of 2 MMR vaccines* or titers (immunity is not mandated)
  - **Varicella** - Documentation of 2 Varicella vaccines* or titers (immunity is not mandated)
  - **Hepatitis B** – Documentation of series of 3 vaccines*, include Hepatis B surface antibody titer if available (required if vaccination done outside the U.S.)
  - **Influenza** -Documentation of vaccination required for personnel here Oct. – March
  - **COVID** – Documentation of vaccination recommended for our records.

*Applies to vaccines administered in the U.S.

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(For CCH Staff only)

☐ **TB Screening** ☐ **Measles** ☐ **Hepatitis B** ☐ **Influenza**

☐ **Rubella** ☐ **Mumps** ☐ **Varicella** ☐ **COVID**

12/2020

CCH Employee Health Services-Tuberculosis Surveillance Questionnaire

Last Name	First Name	Job Title	Department

ID No. or last four digits of SSN:	**DOB:**	Male ☐	Height	Weight
Cell Phone Number	_____	Female ☐	_____Ft_____In	_____lbs.

Please answer the questions listed below:	Yes	No
Have you ever been diagnosed with Tuberculosis?		
Have you ever taken medication for Tuberculosis?		
Have you ever had a Positive Tuberculin or Quantiferon test?		
Have you been exposed to a TB patient since most recent Quantiferon test?		

Please answer the questions listed below, indicating whether you have had any of these problems in the past 2 months ***without a known cause.***	Yes	No
Have you had a fever that lasted for 7 days or longer?		
Have you had a cough that lasted for more than 2 weeks?		
Have you had loss of appetite for longer than 7 days?		
Have you lost 10 or more pounds without dieting?		
Have you had increased or excessive sweating during sleep lasting for more than 7 days?		
Have you had bloody sputum?		
Have you had hoarseness that lasted for more than 7 days?		

Signature_____ Date_____

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(For CCH/PE Staff only)

Questionnaire reviewed by:

Reviewer Signature _____ Date:_____

CONFIDENTIALITY ACKNOWLEDGEMENT

The Cook County Health and Hospitals System, doing business as Cook County Health (CCH) has an ethical and legal responsibility to protect the privacy of its patients and to maintain the confidentiality of protected health information (PHI). CCH workforce members, including but is not limited to employees, volunteers, interns, residents, and vendors must make every effort to prevent unauthorized use or disclosure of medical, personal, financial and other data pertaining to patients, employees, and hospital operations. Therefore, it is imperative that each individual with access to any such information be familiar with and adhere to the CCH HIPAA: Privacy Management policy, No. CC.012.01, and all other applicable CCH and departmental policies and procedures relating to the privacy, security and confidentiality of CCH and patient data. Under no circumstances shall any person access, release or disclose PHI, employee information, or information that is proprietary to CCH to anyone unless it falls within the performance of one's legitimate CCH duties. To ensure that all individuals with access to such information acknowledge their responsibility to protect the privacy and confidentiality of said information, please read the following statements and sign your acknowledgment below:

1. I acknowledge that all medical, financial, and personal information is confidential and protected against unauthorized viewing, discussion, and disclosure.
2. I further understand that all such information is privileged and confidential regardless of its format: electronic, written, overheard, or observed.
3. I agree to use the CCH computer-based information systems for the sole purpose of performing my legitimate job duties.
4. I agree NOT to use the CCH computer-based information systems to access information on myself, my family, or any other person outside the performance of my job duties.
5. I agree to follow all established policies and procedures in relation to changing, deleting, and destroying information in any form.
6. I understand that the passwords assigned to me to access CCH computer-based information systems are confidential, and may not be shared with anyone under any circumstance, nor will I allow any other individual to document under my login or password.
7. I understand that any actions I take in the CCH computer-based information systems are tagged with my unique identifier as established in my user profile, and such actions can be traced back to me. I further understand that I am solely responsible for all activity logged under my user name.
8. I acknowledge that my signature on this Confidentiality Agreement signifies I have read, understand, and am committed to its principles.
9. I understand that this signed and dated document will become a part of my permanent personnel record.

I understand that I may view, use, disclose, or copy information only as it relates to the performance of my duties. Any unauthorized viewing, discussion, or disclosure of this information is a violation of CCH policy and may be a violation of state and federal law. Any such violation may lead to my immediate termination and possible civil liability and/or criminal charges.

_____

Print Name | Department/Title

_____

Signature | Date

_____

Witness by – Signature | Date

PLEASE SELECT YOUR HOME LOCATION

☐ ACHN ☐ CERMAK ☐ CORE ☐ OAK FOREST ☐ PROVIDENT ☐ STROGER

COOK COUNTY HEALTH

HIPAA/FIRE/SAFETY ACKNOWLEDGEMENT AND AGREEMENT FORM

AGREEMENT FOR_____
(ROTATION/CLINICAL PROGRAM)

I, _____
(FIRST NAME / LAST NAME

A, _____ STUDENT AT _____
(TYPE OF STUDENT) (INSTITUTION)

Upon approval by the department, I hereby agree to accept the position of student at Cook County Health location for the period starting _____ and ending _____.

I hereby agree to return by ID Badge to the Department of Medical Education and, if relevant, library books, at the end of my rotation. I further agree to abide by the rules and regulations of Cook County Health & Hospitals System while here on my rotation.

I affirm that I have received basic HIPAA training at my home institution. _____
Initial Here

I affirm that I have received basic fire safety training at my home institution. _____
Initial Here

I affirm that I reviewed, and agree to abide by the HIPPA and fire safety Materials provided to me by the Department of Medical Administration. _____
Initial Here

If I have a blood-borne pathogens exposure, I agree that it is my responsibility to report it to my clinical supervisor, and immediately report to Stroger's employee Health Service *(EHS 3rd Floor, Administration Building, 7:30 am – 4:00 pm)* or if after hours, to the Emergency Room. If EHS is closed at the time of exposure, I agree to report to EHS the following business today. _____
Initial Here

Signature: _____ Date: _____

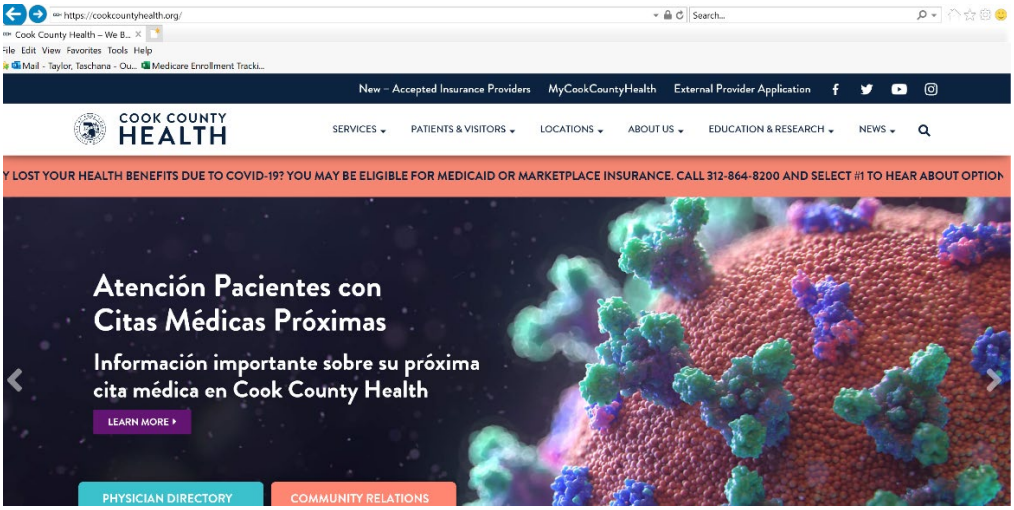
Current Address: _____

Current Phone Number: _____

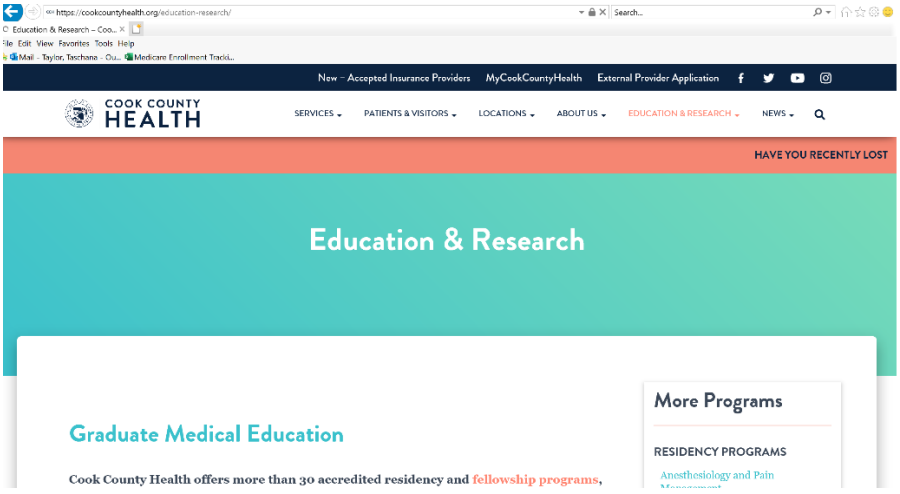
COOK COUNTY HEALTH

Greetings from Cook County Health Department of Professional Education. Below you will find instructions on how to complete the required annual training modules.

1. Go to www.cookcountyhealth.org

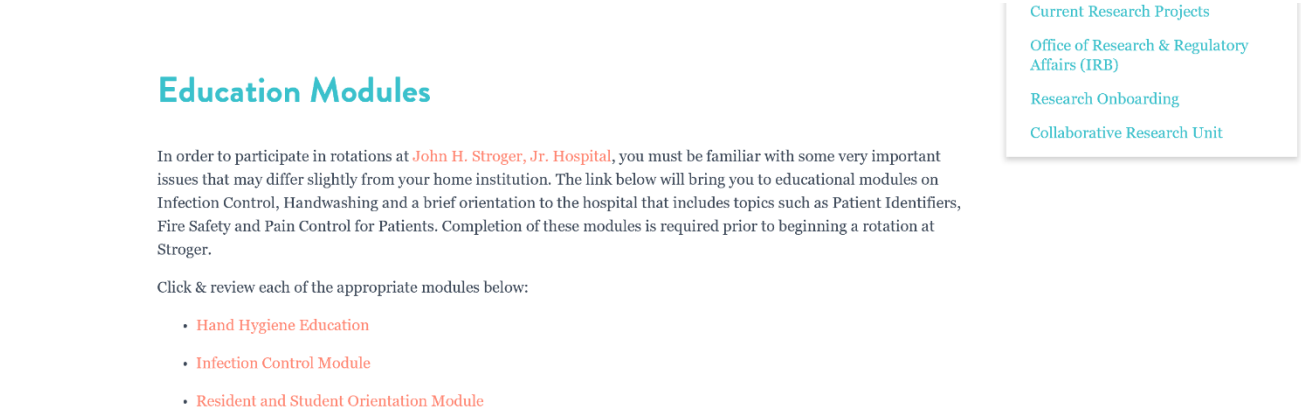


2. Click on Education & Research



3. Scroll down to Education Modules and complete the 3 modules that are listed:

    - Hand Hygiene
    - Infection Control
    - Student Orientation.



Please Note:

-Student Orientation Module is currently down. Please watch the following video and take a photo/screenshot of the final slide to provide as proof of completion.

- https://drive.google.com/file/d/1_nzTjN8XCkUbItFngGF1ZT9QWX_aT3gO/view?usp=sharing

-Hand Hygiene: Please complete the training module and take a screenshot of the final slide as proof of completion.

-Infection Control Module: Please complete the training module. At the end, you will receive a confirmation email. The confirmation email will be requested as proof of completion.

If you have any questions or experience technical issues, please contact:

Rita Coleman rcoleman@cookcountyhhs.org &

Taschana Taylor taschanataylor@cookcountyhhs.org for assistance.

Thank you,

COVID Attestation

COOK COUNTY HEALTH

Rotator Name: _____

Institution: _____

Rotation: _____

Date: <Date>

I agree to produce proof of COVID vaccination before the start of my rotation and to complete an online symptom checker daily. In addition, I will adhere to all of the critical CCH protections such as 4 per elevator car, mask wearing (even in the non-patient care areas), protective eye wear when seeing patients and appropriate social distancing with the understanding there will be "zero tolerance". I understand that if I am not compliant with these safeguards, I may be dismissed from the rotation.

COVID Behavior	Rotator Initials	Coordinator Initials	CCH Staff Initials
Must wear a mask and practice social distancing at all times			
Must wear eye protection (and a mask) when seeing pts. whose COVID status is unknown			
Must observe the CCH 4-person limit on the elevators			
Must complete a symptom checker **daily**			
Must produce proof of COVID vaccination			

Together We Are Stronger...

We must take care of our patients and each other as that is how we can get to the other side of the pandemic. Please support each other and let the CCH Professional Education office know if there is anything you need. Stay safe!