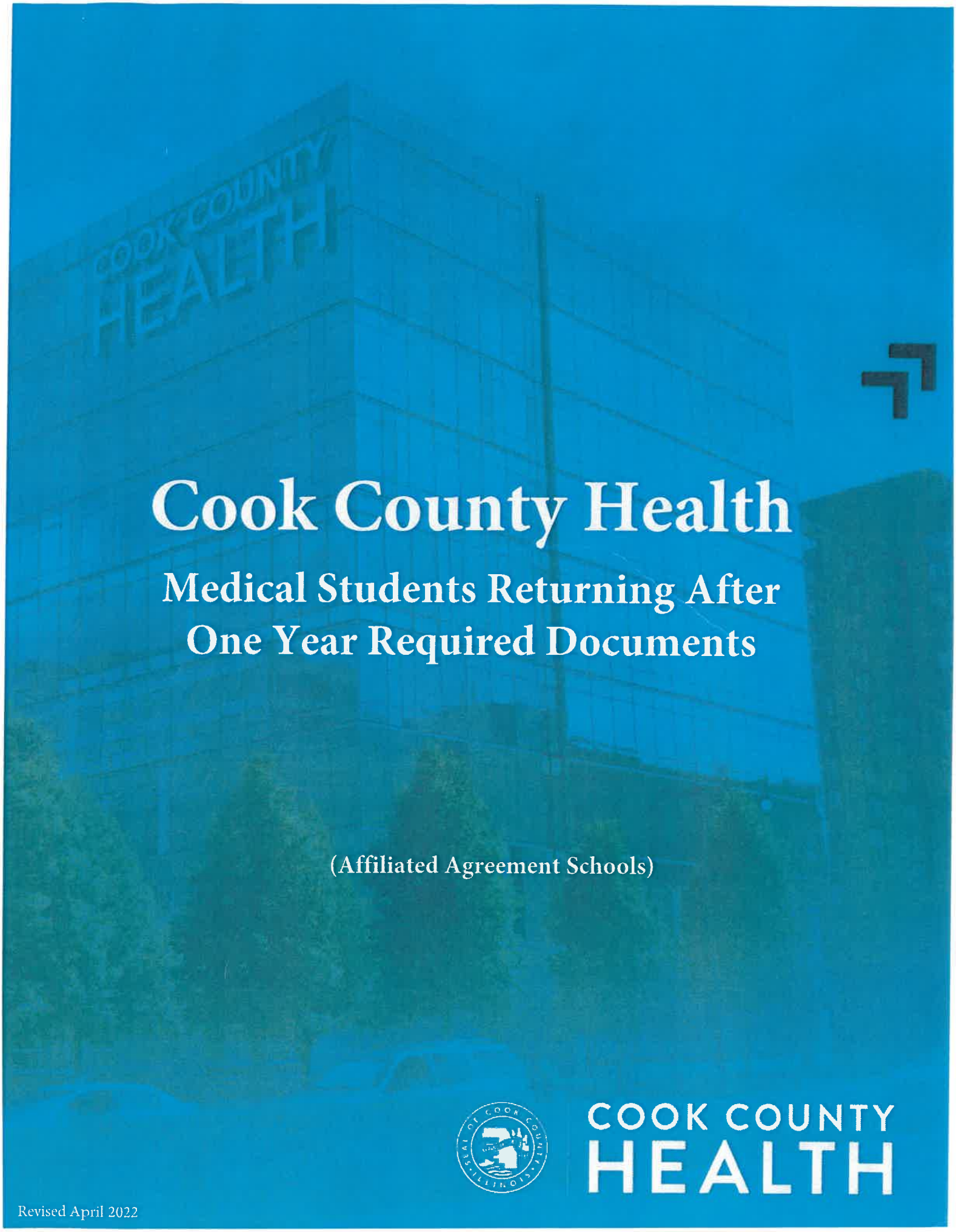

Cook County Health

Medical Students Returning After One Year Required Documents

(Affiliated Agreement Schools)

COOK COUNTY HEALTH

Revised April 2022

Medical Students Returning After One Year Required Documents Checklist

Before Rotation Begins….

☐ **CCH Employee Health Services – Tuberculosis Surveillance Questionnaire**

Influenza Documentation of vaccination required for personnel here October – March

☐ **Printed screen shots of educational modules (hand washing, infection control and student orientation modules)**

https://cookcountyhealh.org/education-research/

Below you will find a link to a Student Orientation Video that will provide you with valuable information for your upcoming student rotation at our facility. Please watch the video and take a screenshot of the final slide to submit as proof of completion.

Here is the link to the orientation:

https://drive.google.com/file/d/1_nzTjN8XCkUbltFngGF1ZT9QWX_aT3gO/view?usp=sharing

☐ **Confidentiality Acknowledgment Form**

☐ **HIPAA/Fire/Safety Acknowledgment and Agreement Form**

Revised 10/2024

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_____

****

(For CCH/PE Staff only)

Questionnaire reviewed by:

Reviewer Signature _____ Date:_____

COOK COUNTY HEALTH

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 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 acknowledgement 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 username.
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 **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, Harrison Square, 8:00 am – 3:30 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 day. _____
Initial Here

Signature: _____ _____ Date: _____ _____

Current Address: _____ _____

Current Phone Number: _____ _____