UK HealthCare Faculty Checklist

Below is the list of required documentation for any faculty member who will bring students to UK for clinical rotation.

- **Clinical faculty will submit required faculty documentation annually.**
- **The Faculty Acknowledgement of Orientation document must be provided for each different clinical area/unit of assignment during the academic year.**
- **It is the responsibility of the Clinical Faculty for maintaining up to date records (for example, submitting a copy of a new CPR card).**
- **Student paperwork must be resubmitted with each clinical group each semester.**
- **In order to add a digital signuatre to the form, please download the form and open in Adobe Acrobat.**

ANNUAL REQUIRED FACULTY DOCUMENTATION	INITIALS	DATE COMPLETED
1. Resume/CV (with recent clinical experience)		
2. Copy of current American Heart CPR		
3. Faculty Member Acknowledgement of Orientation		
4. UK HealthCare Information Security Access Form and Faculty EPIC Verification		
5. UK HealthCare Confidentiality Agreement for Computer Use		
6. Emerging Disease Form		
REQUIRED FACULTY DOCUMENTATION PER CLINICAL GROUP PER SEMESTER	**INITITALS**	**DATE COMPLETED**
1. Clinical Student Contact Information Form and validation of education form for Nursing EPIC Training		
2. Identification Badge Assignment Form		
3. Student Acknowledgement of Orientation		
4. Student Confidentiality of Agreement for Computer Use		
5. Emerging Disease Form		

❖ **Additional documentation may be required per the clinical affiliation agreement. Please refer to your school administration to ensure compliance.**

____________________________________ __________________________

Print Name Date

____________________________________ ______________________

Faculty Signature School of Nursing

____________________________________ ______________________

Student Placement Coordinator Date

UK HealthCare
Faculty Member Acknowledgment of Orientation

1. I have read both the **Orientation Handbook for Nursing Faculty** and the **Orientation Handbook for Nursing Students** and received additional information and instruction, as it pertains to my assignment.
2. I have received infection prevention and control information including COVID-19 from UKHC and school.
3. I have completed a unit-specific orientation, including shadowing a nurse, and am aware of the policy, procedure resources available at UK Hospital and Kentucky Children's Hospital.
4. I have read and agree to abide to the "Living Direct Values" by UKHC.
5. I understand the expectations, and I agree to abide by Hospital policy, protocols, and standards of practice during my assignment at University of Kentucky Hospital.
6. I am competent to care of the patient population being assigned to my students and have submitted an abbreviated resume reflecting that recent experience.
7. I have shared clinical objectives and expectations with the unit Patient Care Manager.

Badges

- The instructor will be responsible for notifying the student placement coordinator promptly for any lost, stolen, or unaccounted badge so that access is terminated for that badge.
- Students will be expected to wear their school issued ID badge/name tag plus their UK Student Nursing Badge when they are at UKHC. Clinical Instructors are to collect the UK Student Nurse Badges at the end of the clinical experience.
- Clinical Instructors are to wear their UKHC personalized badge when onsite.
- Both the Student Placement Coordinator and Hospital Security have been given a list of the students in my clinical group.

HIPAA

- I have reviewed and understand the HIPAA privacy rules restricting use and disclosure of protected health information. I further understand that I am required to comply with the HIPAA rules and that my compliance with them is a condition of my employment, enrollment or affiliation with the University of Kentucky. I understand that failure to follow the HIPAA rules may result in disciplinary action, including termination of my employment, enrollment or affiliation at the University.
- I further understand that should I violate any of the provisions of the HIPAA law I will not be covered by the University's liability insurance and therefore will be personally responsible for any fines, penalties, or imprisonment.
- I have read the orientation guide and received additional information and instruction, as it pertains to my assignment, about Hospital policy, procedure, and practice.
- I agree to abide by the *Behavioral Standards in Patient Care*.
- I understand the expectations, and I agree to abide by Hospital policy, protocols, and standards of practice during my assignment at University of Kentucky Hospital.

Insurance Certification

I acknowledge that the University of Kentucky requires all persons doing clinical rotations at its facilities to have and maintain a health insurance policy. I understand that it is my responsibility to acquire and maintain a health insurance policy throughout the duration of my rotation at the University of Kentucky. I shall provide evidence of such health insurance policy in whatever format is deemed acceptable by the University of Kentucky. I understand that should I fail to obtain a health insurance policy, let my current health insurance policy lapse, or in any way not be covered by a health insurance policy deemed acceptable by the University of Kentucky, my enrollment or affiliation with the University of Kentucky may be terminated.

I hereby acknowledge the University of Kentucky's policy on health insurance coverage, and agree to adhere to its terms.

Name: ____________________________ **Date:** ________________ **Unit:** ________________

Faculty Signature: ______________________________ **Program/School:** ____

Day(s) on Unit: ____________________ **Times on Unit:** ____________ **Dates of Clinical Rotation:** ______________________

UK HealthCare Information Security Access Request Form

(Must complete even if you already have access)

Date: ___________________

Access Level: Employee Non-Employee **Time Frame of Access Needed:** _____________

Previous Student/Employee: Yes No **If Yes: Previous Name:** ______________________

LogonID: _______________________ **UKID #:** ________________________________

Date of Birth: __________________________ **Currently have EPIC Access**: Yes No
(mm/dd/yyyy)

Name: _________________________ _____ ________________________________
First M.I. Last

Job/Role: ____

Department/School: ____

Location/ Building: __________________________ **Cell Phone:** __________________________

Special Instructions: ____

BY SIGNING BELOW, I VERIFY THE EMPLOYEE HAS A NEED FOR SYSTEM ACCESS AND HAS COMPLETED ALL REQUIRED TRAINING.

Nursing Student Coordinator Name: ______________________**Phone:** ____________

Nursing Student Coordinator Signature: ______________________________________

Faculty EPIC (EMR) Verification

- I understand that I must complete classroom training if I am new clinical faculty to UK HealthCare even if I am currently an employee (schedule with Student Placement Coordinator – elaine.smith2@uky.edu)
- I understand that if I have been inactive in the EPIC system for more than 6 months I must complete classroom training (schedule with Student Placement Coordinator – elaine.smith2@uky.edu)
- I understand that there may be potential for additional trainings that may be required in the event of systems changes or upgrades

Name: ____ Date: ________________

Faculty Signature: _______________________________ Date:________________

UK Health Care Confidentiality Agreement for Computer and Pyxis ES Use

Applicant's Name ______________________________ Date of Birth: _________
Link Blue ID: ________________________________ UK ID #: ____________________________

I understand that my access to data, information, and records maintained in the manual and automated information and records systems of UK HealthCare (all hereinafter referred to as Information Systems) is limited to my need for the information in the performance of my job duties. UK HealthCare restricted information may include, but is not limited to, financial data, patient health information (PHI), personally identifiable information (PII), contract information, and data that results in a competitive advantage in the marketplace regardless of its form (i.e. paper, magnetic media, optical media, conversations, film, etc.). The intent of this agreement and UK HealthCare policies is to assure that restricted information will remain confidential through its use, only as a necessity to accomplish the organization's mission.
By my signature below, I affirm that I have been advised of, understand, and agree to the following terms and conditions of my access to information contained in Information Systems.

- **My computer logon ID/password combination is equivalent to my LEGAL SIGNATURE and I will not disclose this password to anyone or allow anyone to access Information Systems using my logon ID/password combination.**
- **I will password protect and encrypt any portable electronic device that contains patient (or other restricted) information.**
- **I am responsible and accountable for all entries made and all retrievals accessed using my logon ID/password, even if such action was made by me or by another due to my intentional or negligent act or omission.**
- **I will not access any Information System using a logon ID/password other than my own.**
- **I will not access or request access to any information for which I have no responsibility. In addition, I will not look up my own medical information.**
- **If I have reason to believe that my logon ID/password has been compromised, I will immediately notify the Office of Corporate Compliance and the Director of Information Security.**
- **I will not disclose any restricted information unless required to do so in the official capacity of my employment or contract. I also understand that I have no right of ownership interest in any restricted information.**
- **I will comply with all policies and procedures and other rules of UK HealthCare relating to confidentiality of information and access.**
- **I understand that my use of the UK HealthCare Information Systems may be periodically monitored to ensure compliance with this agreement.**
- **I will dispose of restricted information properly in accordance with all applicable policies.**
- **If a Department standard is more restrictive than this agreement, I will abide by that Department's standard.**
- **I agree not to use the information in any way detrimental to the organization and will keep all such information confidential.**
- **This agreement cannot be terminated or canceled, nor will it expire.**
- **I understand that if I violate any of the above terms, I will be subject to disciplinary action, including discharge, loss of privileges, termination, legal action, or any other**

PYXIS

- **I understand that my ID, in combination with the confidential password that I will later select, will be my electronic signature for all of my transactions on the system for both controlled substance and patient care record keeping purposes. A time stamp and date will also be affixed to my transactions. These records will be maintained and archived as per the policies of the University of Kentucky Hospital and will be available for inspection by the Drug Enforcement Administration, as is currently the case with my handwritten records for controlled substances.**
- **I also understand that, to maintain the integrity of electronic signature, I must not and will not give my personal password to any other individual. Unauthorized access, release or dissemination of this information may subject me to disciplinary action. Should I have any suspicion that my personal password has become known to another individual, I will change it immediately and if deemed appropriate, will immediately report such to my supervisor.**

Faculty Signature: __________________________________ Date:_________________

Emerging Diseases/COVID-19 Questionnaire

****

First name:		
Last name:		
Preferred contact number:		
School:		
Preceptor/Sponsor:		
Please respond to the following questions:	Yes	No
Do you have a new cough unrelated to seasonal allergies?		
Do you have new muscle aches/pains?		
Do you have new shortness of breath?		
Do you have a new sore throat (not associated with seasonal allergies)?		
Do you have vomiting or diarrhea?		
Do you have a fever of 100.0 or greater?		
Have you experienced a loss of taste or smell?		
Have you or any of your close personal contacts been diagnosed with COVID-19, within the last 14 days and are you required to isolate by the local health department?		
Have you or any of your close personal contacts traveled to the Democratic Republic of the Congo (DRC) or Guinea in past 30 days?		

Any "yes" responses must be cleared through UK HealthCare Infection Prevention and Control.

If "yes" to any of the above questions, please contact **UK HealthCare Infection Prevention and Control at 859-323-6337** prior to presenting to any UK HealthCare facility for orientation, work assignment, or clinical/learning experience.

****

Signature of individual completing form: ______________________ Date: ___________

Name of agency/instructor reviewer: _________________________ Date: ___________

For any "yes" answer, contact Infection Prevention and Control (IPAC):

IPAC rep. name: _________________________ Cleared for work/clinical: ___Yes ___ No

UK HealthCare

NURSING STUDENT CLINICAL ROTATION

Daily Assignment Sheet

School:____

Clinical Instructor: ___________________________________

Year/semester of students: _________________________

Date/time on unit: ___________________________________

Please list key objectives for clinical rotation(or attach):

1. ____

2.____

3.____

Student	Assigned Patient	Room #	Patient's Nurse	Medication Administration
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Activities on unit:

Appendices B: Student Forms

Clinical Student Contact Information

Nursing Program: ___________________________ Faculty Name: ___________________________

Nursing Course #: ___________________________ Faculty Phone: ___________________________

Semester & Year: ___________________________ Clinical Unit: ___________________________

Student Name	Address	Phone #
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Validation of Education for Nursing Student EPIC Training

I verify that the students listed above have viewed the student module and have completed the appropriate competency with a 100%.

_______________________________ _____________________________________

Faculty Signature Date

____

Name (Printed)

Identification Badge Assignment Form

School Affiliation: _________________ Semester/Year: ____________________________

Faculty Member Name: ____

Faculty Member Phone Number: ____________Faculty UK ID Number: ____________

Clinical Rotation Dates: Start __________________ End ___________________

Student Name	UK ID #	RN Student Nurse Issued Badge #	Location of Clinical/Synthesis (ED, OR, KCH, PAV A, Chandler, Good Sam)

Please email completed form to student placement coordinator at elaine.smith2@uky.edu and SecurityIDBadges@uky.edu at least one week prior to start date in order for the badges to be activated.

Student Acknowledgment of Orientation

- I have read the orientation guide and received additional information and instruction, as it pertains to my assignment, about Hospital policy, procedure, and practice.
- I agree to abide by the "Living Direct" Values of UKHC.
- I understand the expectations, and I agree to abide by Hospital policy, protocols, and standards of practice during my assignment at University of Kentucky Hospital.
- I have read the orientation guide and received additional information and instruction, as it pertains to my assignment, about Hospital policy, procedure, and practice.
- I understand the expectations, and I agree to abide by Hospital policy, protocols, and standards of practice during my assignment at University of Kentucky Hospital.

Additional Information provided by Clinical Instructor:

_____1. Layout of unit (supplies, reference books, Fire alarm, extinguisher, evacuation route, etc.).
_____2. Use of Nursing Flowsheets and documentation system
_____3. Where to store personal items
_____4. Teaching Sheets & Resources
_____5. Resources for Patient Care: Care Coordinators, Case Managers, Support Services
_____6. Unit Routines (VS, Weights, Baths, etc.)
_____7. Medication System (PYXIS and/or E-MAR)
_____8. IV set ups and infusion devices
_____9. Standard and Specialty Beds (if applicable)
_____10. Restraints (if applicable)
_____11. Emergency situations and codes
_____12. Other equipment, procedures, standards: ___________________________________
_____13. Use of Social Media/personal email
_____14. Infection Prevention and Control information including COVID-19 from UKHC and school

HIPAA

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I further understand that should I violate any of the provisions of the HIPAA law I will not be covered by the University's liability insurance and therefore will be personally responsible for any fines, penalties, or imprisonment.

Insurance Certification

___I acknowledge that the University of Kentucky requires all persons doing clinical rotations at its facilities to have and maintain a health insurance policy. I understand that it is my responsibility to acquire and maintain a health insurance policy throughout the duration of my rotation at the University of Kentucky. I shall provide evidence of such health insurance policy in whatever format is deemed acceptable by the University of Kentucky. I understand that should I fail to obtain a health insurance policy, let my current health insurance policy lapse, or in any way not be covered by a health insurance policy deemed acceptable by the University of Kentucky, my enrollment or affiliation with the University of Kentucky may be terminated.

I hereby acknowledge the University of Kentucky's policy on health insurance coverage, and agree to adhere to its terms.

Student Name (print): __________________________ Student Signature: _________________________Date: ___________

School: _________________________ Dates/Times on Unit______________________________ Unit: _______________

Faculty/Preceptor Signature:____

UK Health Care Confidentiality Agreement for Computer Use

Applicant's Name ________________________________ UK ID #: __________________________ Date of Birth: _________

I understand that my access to data, information, and records maintained in the manual and automated information and records systems of UK HealthCare (all hereinafter referred to as Information Systems) is limited to my need for the information in the performance of my job duties. UK HealthCare restricted information may include, but is not limited to, financial data, patient health information (PHI), personally identifiable information (PII), contract information, and data that results in a competitive advantage in the marketplace regardless of its form (i.e. paper, magnetic media, optical media, conversations, film, etc.). The intent of this agreement and UK HealthCare policies is to assure that restricted information will remain confidential through its use, only as a necessity to accomplish the organization's mission.

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- I will password protect and encrypt any portable electronic device that contains patient (or other restricted) information.
- I am responsible and accountable for all entries made and all retrievals accessed using my logon ID/password, even if such action was made by me or by another due to my intentional or negligent act or omission.
- I will not access any Information System using a logon ID/password other than my own.
- I will not access or request access to any information for which I have no responsibility. In addition, I will not look up my own medical information.
- If I have reason to believe that my logon ID/password has been compromised, I will immediately notify the Office of Corporate Compliance and the Director of Information Security.
- I will not disclose any restricted information unless required to do so in the official capacity of my employment or contract. I also understand that I have no right of ownership interest in any restricted information.
- I will comply with all policies and procedures and other rules of UK HealthCare relating to confidentiality of information and access.
- I understand that my use of the UK HealthCare Information Systems may be periodically monitored to ensure compliance with this agreement.
- I will dispose of restricted information properly in accordance with all applicable policies.
- If a Department standard is more restrictive than this agreement, I will abide by that Department's standard.
- I agree not to use the information in any way detrimental to the organization and will keep all such information confidential.
- This agreement cannot be terminated or canceled, nor will it expire.
- I understand that if I violate any of the above terms, I will be subject to disciplinary action, including discharge, loss of privileges, termination, legal action, or any other

____ __________________

Student Signature Date

Emerging Diseases/COVID-19 Questionnaire

****

First name:		
Last name:		
Preferred contact number:		
School:		
Preceptor/Sponsor:		
Please respond to the following questions:	Yes	No
Do you have a new cough unrelated to seasonal allergies?		
Do you have new muscle aches/pains?		
Do you have new shortness of breath?		
Do you have a new sore throat (not associated with seasonal allergies)?		
Do you have vomiting or diarrhea?		
Do you have a fever of 100.0 or greater?		
Have you experienced a loss of taste or smell?		
Have you or any of your close personal contacts been diagnosed with COVID-19, within the last 14 days and are you required to isolate by the local health department?		
Have you or any of your close personal contacts traveled to the Democratic Republic of the Congo (DRC) or Guinea in past 30 days?		

Any "yes" responses must be cleared through UK HealthCare Infection Prevention and Control.

If "yes" to any of the above questions, please contact **UK HealthCare Infection Prevention and Control at 859-323-6337** prior to presenting to any UK HealthCare facility for orientation, work assignment, or clinical/learning experience.

****

Signature of individual completing form: ______________________ Date: ___________

Name of agency/instructor reviewer: _________________________ Date: ___________

For any "yes" answer, contact Infection Prevention and Control (IPAC):

IPAC rep. name: _________________________ Cleared for work/clinical: ___Yes ___ No

Student Exit Feedback

Please have students copy and paste the below link into an internet browser at the end of their clinical rotation/synthesis experience or use the QR code to access the survey.

We appreciate you sharing this information with us in an effort to improve educational experiences and opportunities at UK Healthcare and Kentucky Children's Hospital.

https://uky.az1.qualtrics.com/jfe/form/SV_4ZNhdFFKJzkcLeC