Learner Name: Institution/Program:

PRESBYTERIAN Medical Education

Department Use Only
Submission Date:

Learner Onboarding Completion Checklist

All documents must be submitted *at least 30 days before* the rotation start date.

STEPS

To obtain an educational rotation at any Presbyterian Healthcare Services facility, please follow these steps:

1. Confirm with your institution that an educational affiliation agreement is in place
2. Identify and secure a Presbyterian provider as your primary preceptor
3. Complete all required training (requirements listed in *Learner Training & Commitment* form)
4. Complete, compile, and submit all required paperwork

REQUIRED FORMS & ATTACHMENTS

Please *electronically* complete all forms in their entirety. All required fields must be complete and attachments included in order to process. *Attachments are marked with an asterisk (*).*

Please check off each item below when complete.

- ☐ 1. Learner Onboarding Completion Checklist (this form)
- ☐ 2. Learner Information Form
- ☐ 3. Learner Training & Commitment
- ☐ 4. Clinical Attestation for Placement
- ☐ 5. Health Screening/Immunizations Form
  - ☐ 5a. Upload proof of COVID-19 vaccinations
  - ☐ 5b. Upload proof of mask fit testing
- ☐ 6. Background Check Verification (completed by learner coordinator/supervisor)
  - ☐ 6a. *NMDOH Caregivers Criminal History Screening clearance letter
- ☐ 7. *Letter of Good Standing from Educational Institution

SIGNATURES

To the best of my knowledge, all forms are completed in their entirety and attachments included.

Learner

Name: _____ Signature: _____ Date: _____

Coordinator/Supervisor

Name: _____ Signature: _____ Date: _____

Learner Name: Institution/Program:

PRESBYTERIAN Medical Education

Department Use Only
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Learner Information Form

Please complete this form in its entirety.
Required fields are marked with an asterisk (*).
This form must be updated when rotation dates are changed or added.

LEARNER INFORMATION

Basic Information

*Legal First Name: _____ Preferred First Name: _____

*Last Name: _____ Current Credentials: _____ Pronouns: Select

*DOB: _____ *Last 4 #s of SSN (residents) or Student ID (students): _____

*Email Address: _____ *Cell #: _____

*Preferred Communication Method(s): _____

Permanent Address: _____
Street City State Zip

Local Address *(if different):* _____
Street City State Zip

*Are you a current PHS employee? Select One

*Have you completed rotations at a PHS location in the past? Select One

If so, most recent rotation dates: _____ to _____

Emergency Contact

*Name: _____ *Relationship: _____

*Phone #: _____ Email: _____ *City/State: _____

Learner Name: Institution/Program:

License Information

*NM Professional License #: _____ *License Type: _____

Residents Only:

NPI #: _____ DEA #: _____ Institution-issued DEA #? Select One

INSTITUTION & PROGRAM INFORMATION

Basic Information

Institution: _____ Program: _____

Campus (if applicable): _____ City: _____ State: _____

Program Contact

Name: _____ Title: _____

Email: _____ Office #: _____ Fax #: _____

If the institution/program has any requirements of which PHS and/or your preceptor should be aware, please list them here:

ROTATION INFORMATION

Please enter all known upcoming rotations for this learner below.

This form must be updated when rotation dates are changed or added.

Primary Preceptor *(name & credentials)*	**Start Date**	**End Date**	**Department**	**Primary Location**

Learner Name: Institution/Program:

DEMOGRAPHIC INFORMATION

Inclusion, Diversity, and Equity: Unified in our purpose, strengthened by our differences.

We commit to an inclusive and equitable environment where everyone is valued and empowered for success. Our environment reflects the diversity of our community, learns from all perspectives, provides affordable, accessible and culturally appropriate health care and champions health equity for our New Mexico communities.

Inclusion and diversity begin in our workplace. They are key to helping our workforce Thrive by helping create an environment where each employee is valued and heard.

We encourage you to complete the questions below. Completion of this section is entirely optional. If you prefer not to answer a question, simply skip it.

Race/Ethnicity

What is your race? Select the option that most closely represents you

Is your ethnicity Hispanic, Latino, or of Spanish origin? Select the most accurate option

Additional racial and/or ethnic identities you hold: _____

Language

What is your primary language at home? Select a language

If you have one, what is your secondary home language? Select a language

Sex

What was your sex designated at birth? Unsure

What is your legal designated sex now? Unsure

Gender

What is your gender identity? Select the option that most closely represents you

Additional words you use to describe your gender: _____

Do you consider yourself transgender, gender diverse, or a gender different than what you were designated at birth? Select one

Sexual Orientation

How do you identify your sexual orientation? Select the option that most closely represents you

Additional words you use to describe your sexual orientation/sexuality: _____

Disability Status

Do you have a disability and/or consider yourself disabled? Select one

Veteran Status

Do you consider yourself a veteran and/or did you serve in the Armed Forces? Select one

Learner Name: Institution/Program:

PRESBYTERIAN Medical Education

Department Use Only
Submission Date:

Learner Training & Commitment

Agreement to the items below is required of all learners rotating at any Presbyterian Healthcare Services facility.

Please review thoroughly and attest below.

REQUIRED TRAINING

Each material listed below is a link to the online PDF.

Please check off each training as you complete it:

- ❑ Organizational Orientation and Compliance and Ethics
- ❑ Cultural Intelligence and Equal Treatment
- ❑ General Safety
- ❑ Fall Risk and Prevention
- ❑ Infection Control
- ❑ Blood Transfusion Reactions

REQUIRED TERMS

Medical Records Confidentiality

I understand that while performing duties under this Agreement, I might have access to records relating to the treatment of patients at the Hospital ("Medical Records"). I hereby agree not to disclose any Medical Records or the contents of any Medical Records except in accordance with the Health Insurance Portability and Accountability Act (“HIPAA”) to anyone other than (i) any workforce member of Presbyterian Healthcare Services (“PHS”) who needs to know the contents of the Medical Records in the performance of their job function; and (ii) members of the Hospital Medical Staff involved in the direct care of the concerned patient. To the extent that the Medical Records relate in any way to the treatment of drug, alcohol or substance abuse, I acknowledge (i) that I am bound by regulations governing confidentiality of Substance Use Disorder Patient Records, 42 C.F.R. Part 2. and (ii) if necessary, I will resist in judicial proceedings any efforts to obtain access to the Medical Records, except as provided in the above-cited regulations. To the extent that the Medical Records contain test results governed by the Human Immunodeficiency Virus Test Act (HIV/AIDS Test Results/Treatment), or to other sexually transmitted infections/diseases which may be protected by state law, PHS makes the following disclosure to me regarding such records:

"This information has been disclosed to you from records whose confidentiality is protected by State Law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by State law. A person who makes an unauthorized disclosure of this

Learner Name: Institution/Program:

information is guilty of a petty misdemeanor and shall be sentenced to imprisonment in the county jail for a definite term not to exceed six months or the payment of a fine of not more than five hundred dollars ($500), or both".

Non-Discrimination

In performing duties within any PHS Hospital, I understand that I and the Hospital will make services available for the sick of the area served without regard to race, color, ancestry, national origin (including limited English proficiency), citizenship, religion, sex (including pregnancy, childbirth or related medical conditions), marital status, sexual orientation, gender identity or expression, veteran status, military status, family care or medical leave status, age, physical or mental disability, medical condition, genetic information, ability to pay, or any other protected status.

Compliance with Hospital Policies and Applicable Law

In performing duties within the Hospital, I agree to comply with any Rules and Regulations, Hospital policies and procedures, standards and requirements of the Joint Commission on the Accreditation of Health Care Organizations (including requirements for training and competencies), Medicare, Medicaid, and other licensing and accrediting agencies, and all applicable federal and state statutes and regulations.

I acknowledge that I have read and understand the Hospital's Students/Residents Rules/Guidelines and Requirements specific to Hospital rotation.

Limitation on Liability

While performing duties within the Hospital, I understand that PHS will not be liable to any Medical & Clinical Students, Residents, and/or Fellows, or any other person affiliated with the Program or employed by the Program or its agencies or branches in connection therewith, nor to any person making claim on behalf of such Medical & Clinical Students, Residents, and/or Fellows, instructor, or other persons, for any injury, death or damage to the persons or property of such Medical & Clinical Students, Residents, and/or Fellows, instructor, or other person arising from any cause whatsoever during the scheduled training within the Hospital when such Medical & Clinical Students, Residents, and/or Fellows, instructor, or other person is participating in training in connection with the Program; unless injury, death or damage to the person or property is proven to be caused by the grossly negligent acts or willful misconduct of PHS, its officers, or employees.

Exposure to Blood or Body Fluids

While performing duties within the Hospital, I understand that it will be my responsibility to report any exposures to blood or body fluids to a representative of the Hospital as well as to my primary instructor at the Program and to follow the exposure control plan which has been developed and adopted by the Program.

Illness or Injury

I understand that it is my responsibility to become familiar with and to comply with the particular policies of the Program related to illness or injury while on the Hospital premises, including reporting of illness or injury and procedures to be followed. If I am unfamiliar with any policies or procedures in regard to illness or injury, I agree to ask representatives of the Program for

Learner Name: Institution/Program:

clarification as soon as possible.

Supervision

While performing services within the Hospital, I understand that I am not to initiate any patient care activities without the specific instruction of medical staff, which specifically outlines the duties to be performed.

RESPONSIBILITIES

Both the primary preceptor and any listed alternate preceptors must be member(s) of the medical staff with unrestricted, unsupervised privileges to perform anticipated patient care activities and clinical procedures.

All learner participation will be under the supervision of an approved preceptor.

Preceptor Responsibilities:

1. Notify the attending physician prior to any learner's involvement in individual patient care.
2. Obtain patient consent and acknowledgement of the learner's presence and/or participation during any appropriate patient care activity.
3. Direct, monitor and supervise all activities taken by the learner.
    a. Determine which experiences are appropriate for learner involvement.
    b. Supervise the medical care provided by the learner and other activities necessary to accomplish objectives
4. Provide guidance and feedback to the learner.
5. Review the *Medical & Clinical Students, Residents, and Fellows Mentored by Physicians and Advanced Practice Clinicians* policy (MED.PDS.009) and attachments, the PreceptorTip Sheet, and all sections of this document.
6. Comply with all applicable state, local and federal laws and regulation relating to the precepting of a learner, including adherence to all billing, coding, and documentation regulations.
7. Perform on-site orientation for each learner (for whom you are a primary or alternate preceptor) at the start of their first day with you or first time at a new clinical site. Complete this orientation before the learner engages in any patient care. Use the On-Site Orientation Checklist or an approved alternative document to perform this orientation.
8. Surgical/ Obstetrical procedures require mandatory OR orientation for all recognized learners who will do an OR rotation or observe a surgery or procedure in the OR.
    a. Ensure the learner completes OR orientation if necessary
    b. Adhere to OR Orientation Expectations and Guidelines (see Attachment B).
9. Participate with faculty and the learner in the evaluation of the learner's performance in the clinical setting.
10. If learner performance is less than satisfactory during the rotation, reporting such to the appropriate Office of Medical Staff Affairs (MSA) at the facility where the rotation took place and the Medical Education department.

Learner Name: Institution/Program:

Learner Responsibilities

1. Complete the required rotation educational materials.
2. Ensure completion of on-site orientation at the beginning of your first day with each new preceptor (primary and alternate) and at each new clinical site before engaging in patient care.
3. Regard your preceptor(s) as an instructor.
4. Provide patient care under the supervision of the preceptor in keeping with national patient safety goals.
5. Accept responsibility for keeping professional matters confidential in the manner of a true client-patient relationship.
6. Conduct oneself in an ethical and professional manner.
7. Maintain a personal appearance befitting a professional while adhering to PHS dress code specific to the role in which you will serve during this rotation.
8. Comply with all requirements of supervision.
9. Wear photo identification badge at all times.

LEARNER COMMITMENT

Please initial the lines below to attest to the necessary aspects of rotating:

_____ I attest to completing all the training materials listed above.

_____ In the performance of my work for Presbyterian, I agree to abide by the policies included in the listed training materials.

_____ I agree to protect any Presbyterian Confidential Information that I obtain access to through my workforce role at Presbyterian and will not disclose such information in violation of HIPAA or other privacy regulations or Presbyterian policy.

_____ I reviewed and agree to the Terms listed above.

_____ I reviewed and agree to the Learner Responsibilities listed above.

_____ I reviewed the learner policy (MED.PDS.009) and agree to adhere to all aspects of it and its attachments.

_____ I agree to complete an on-site orientation with each preceptor and at each clinical site during my rotation(s).

_____ If applicable, I agree to complete the necessary OR orientation(s) before entering the OR.

_____ If I have questions or concerns regarding any of the material, I will follow up by asking my Presbyterian manager, the Presbyterian Vice President for Corporate Compliance, (505-923-8544) or the toll-free Compliance Hotline (1-888-435-4361).

SIGNATURES

Learner:

Name: _____ Signature: _____ Date: _____

Coordinator/Supervisor:

Name: _____ Signature: _____ Date: _____

PRESBYTERIAN **CLINICAL STUDENTS/INSTRUCTOR ATTESTATION FOR CLINICAL PLACEMENT**

Please review, acknowledge understanding of requirement and indicate agreement to follow all requirements.

Clinical Attestation for Presbyterian Requirements for Clinical Placement	
Requirements:	**Understanding of Requirement**
1. I understand that I must follow all the PPE requirements as presented in the Presbyterian protocols.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
2. I understand that I will always wear surgical face masks issued by Presbyterian while I am on Presbyterian property.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
3. I understand that I will maintain social distancing (to the maximum extent possible) and all safety measures that minimize potential exposure to infective agents.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
4. I also understand that failure to comply with these requirements may result in my termination of my current or future rotations at Presbyterian facilities	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
5. I understand that as a clinical student I will generally not be assigned COVID-19 positive patients nor PUIs during my clinical rotation.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
6. If I am assigned to a COVID-19 positive patient or PUI, I should inform my instructor before proceeding.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
7. If my clinical experience is granted access to a COVID-19 positive patient or PUI, I will work with my educational institution to undergo respirator fit-testing before I begin this approved patient assignment/experience. If required, I understand that I cannot participate in this experience unless I am fit-tested first by my educational institution and have this testing documented. I further understand that if my clinical experience is granted access to COVID-19 positive patients or PUI's and I am uncomfortable with seeing such patients, I must inform my instructor immediately.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
8. I will complete all Presbyterian required education located in the LMS including infection control modules/ infectious diseases including COVID information before I start my clinical rotation.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
9. I understand that I will review all hospital and clinic guidelines/policies specific to my rotation.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
10. Before placement in the assigned clinical area I will: • Inform my academic organization instructor/management/coordinator if I have recently traveled to another state; been exposed to a potentially COVID positive person, experienced COVID like symptom(s), and/or tested positive for COVID.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.

Clinical Attestation for Presbyterian Requirements for Clinical Placement	
Requirements:	**Understanding of Requirement**
• May need to be excluded from clinical rotations if any of the above situations exist.	
11. During facility entry screening at the Presbyterian clinical site, I will: • Participate actively and honestly in the screening process • Leave the premises if found to meet the entry exclusion criteria • Inform the school if I have been excluded • Wear the PHS supplied PPE if I pass the screening	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
12. During the clinical rotation I will inform my preceptor/ unit management rapidly if: • I begin to feel symptomatic of COVID-19 • I believe that I have been exposed to COVID-19	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
13. I understand that if I do not comply and am not honest during the screening process or while present in the clinical rotation on-site, I will be asked to leave the PHS property and will be reported to my academic coordinator. I also understand that I may not be allowed to continue the present and future clinical rotations at Presbyterian.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
14. I understand how to access COVID-19 testing.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.
15. I understand and will comply if asked to leave the Presbyterian site if the clinical environment becomes unsafe for external visitors.	☐ Yes, I understand and will follow. I will ask questions if I need clarification.

I have read this attestation and agree to comply with all requirements. If I have questions at any time I agree to ask when I need clarification. This section must be signed, and all sections completed accurately.

Name (please print legibly): _____

Signature (please do not type): _____ Date: _____

Name of School: _____ Program: _____

Coordinator's Name: _____

Coordinator's Contact Information (email/phone number): _____

If you have any questions, please email your Presbyterian contacts for clinical rotation placements.

For Clinical Education

- For Nursing Placements: nsgstudentcoordinator@phs.org
- For Allied Health: clinicalcoordinator@phs.org

For Medical Education Placements: contact mededu@phs.org

-- Please do not alter this form --

Learner Name: Institution/Program:

PRESBYTERIAN Medical Education

Department Use Only
Submission Date:

Learner Health Screening Verification

Required for acceptance to and completion of medical/clinical rotations.

Educational institutions/programs must retain proof of learner health screenings and immunizations, and for providing these records upon PHS request consistent with prior written authorization from the learner which shall not unreasonably be withheld.

***Full Legal Name of Individual Being Cleared:** _____

If the learner qualifies for an exemption any of the items listed, please contact Medical Education directly.

SCREENINGS

10-Panel Urine Drug Screening

Passed 10-panel drug screening required for all learners completing rotations. Please attach.

Date of Passed Screening: _____

Tuberculosis Screening (TB Test)

A negative result on one of the options listed below is required within the past 12 months.

Negative PPD skin test: _____ **-OR-** Two (2) negative TB skin tests: _____ _____

If there was a past positive TB test result, please provide dates for one of the following:

Quantiferon TB Gold Nonreactive Result: _____ Negative Chest X-Ray: _____

Completion of Annual TB Questionnaire (*required annually)*: _____

IMMUNIZATIONS

Please list dates of immunizations and/or positive titers *(most recent listed first):*

Hepatitis B (series):				
Measles, Mumps, & Rubella (MMR):				
Tetanus, Diphtheria, & Pertussis (TDaP):				
Varicella:				

Learner Name: Institution/Program:

Flu Vaccine

Those who opt not to receive the flu vaccine must wear a face mask in all patient care areas throughout the duration of flu season.

Receipt Date of Annual Influenza Vaccine: _____ ☐ I Decline the Flu Vaccine

COVID-19 Vaccine

A complete COVID-19 vaccine series with a booster is mandated for all New Mexico healthcare workers, including students, residents, and fellows.

Date(s) of receipt of COVID-19 Vaccines: _____ & _____ of Booster: _____

Brand of Vaccine: Select One Brand of Booster: Select One

Proof of COVID-19 vaccination must be provided by the learner. Upload here.

☐ I am Exempt *(if checked, leave all previous fields in this section blank)*

Exemptions:
In order to rotate at a PHS facility, unvaccinated learners must meet all the requirements for exemption under the NMDOH regulations and their educational institution must document this. Weekly testing as required under the NMDOH regulations must be followed and documented by the academic program/school. Failure to comply will result in immediate dismissal from rotation.

MASK FIT TESTING

Providers may unexpectedly encounter a COVID-positive patient or patient under investigation at any time. Therefore, all learners must be able to don a fit-tested n95 respirator.

All learners must pass a fit test for at least one of the Presbyterian-approved mask models (list provided upon request) no more than one year prior to their rotation start date. Presbyterian will provide PPE on-site for learners and will not acceptoutside respirators in place of Presbyterian-provided PPE. Educational institutions areresponsible for fit testing their learners and educating learners on proper PPE usage.

Proof of passed Mask Fit Testing must be provided by the learner. Upload here.

Mask Manufacturer/Model: Select One Date of passed fit test: _____

SIGNATURES

The undersigned do hereby attest that all information provided on this form is accurate and true.

Learner:

Name: _____ Signature: _____ Date: _____

Coordinator/Supervisor:

Name: _____ Signature: _____ Date: _____

Learner Name: Institution/Program:

PRESBYTERIAN Medical Education

Department Use Only
Submission Date:

Learner Background Check Verification

The learner's educational coordinator or supervisor must complete this form.
All fields must be completed for this form to be processed.

***Full Legal Name of Individual Being Cleared:** _____

BACKGROUND CHECKS

New Mexico Caregivers Criminal History Screening (CCHS)

Required for all non-licensed learners (licensed RNs & residents exempt).
Clearance letter must be signed within the past 12 months. Please attach.

Date of Clearance: _____

The CCHS includes checks of the following: state and federal criminal history background, NM Employee Abuse Registry, Multi-state Nurse Aide Registry, Office of Inspector General (OIG) List of Excluded Individuals/Entities, and National Sex Offender Registry.
For more information, visit the NM DOH website at: https://nmhealth.org/about/dhi/cchsp/

Federal Excluded Entity Database

Please visit www.sam.gov and search the learner's name. Please save receipt of the learner's clearance and attach copy.

Date of Clearance Confirmation: _____

If the learner is not cleared in the database, please contact PHS Medical Education department promptly. The individual may be ineligible to rotate or work at Presbyterian.

SIGNATURE

I the undersigned do hereby attest that the above were checks I performed and, to the best of my knowledge, the learner cleared through both systems.

Coordinator/Supervisor

Name: _____ Signature: _____ Date: _____