University of Miami Hospital

Date: _____ Name of School _____

To:

Attn: Erika Jamieson, MSN, RN
Clinical Educator
Phone: 305-689-4586
University of Miami Hospital
1400 N.W. 12th Ave.
Miami, Fl, 33136

Student Information:

_____, _____, _____
(PRINT NAME OF STUDENT) (Last 4 digits SS #) (HOME PHONE #)

_____
(COMPLETE STUDENT'S HOME ADDRESS: STREET, CITY, STATE, ZIP CODE)

Type of Educational Program: _____ Course Number: _____

Semester Objectives attached to this Attestation: ☐ Yes ☐ No (Why? _____)

Clinical Dates: _____to_____ Clinical Day(s): _____ Time of Rotation: _____

Clinical Requirements:

By signing this form, I attest to the fact that the student(s) named on this or/and accompanying sheet, has/have successfully completed, according to the standards set by University of Miami Hospital, the following:

1. CPR expires on: _____

2. Medical Clearance Statement to include:
( ) Negative PPD/Chest X-Ray (performed within *ONE* year)
( ) Immunizations and Hepatitis B Vaccine
( ) Statement from Physician that student is capable of participating in program

3. <u>Background Checks on file at school, meeting contract specifications</u>:

a) Social Security number verification;
b) Seven Year Multi-County or Statewide Felony
c) Two Standard Employment History References;
d) HHS/OIG List of Excluded Individuals/Entities – GSA List of Parties Excluded from Federal Programs
e) Violent Sexual Offender and Predator Registry Search
f) U.S. Treasury, Office of Foreign Assets Control (OFAC), List of Specially Specially Designated Nationals (SDN)
g) Education verification (Highest Degree Received)
h) One Professional Licensure Verification-Professional Disciplinary Action Check; and Related Misdemeanor Criminal Record search;
I) Certification & Designation Check.

4. Education
a. Self Study UMH General Orientation completed on: ___ b. Orientation Post-test completed on: ___

Print Name of School Program Coordinator/Instructor: _____

Signature of School Program Coordinator/Instructor: _____
Phone: (____) _____ – _____

CONFIDENTIALITY STATEMENT

The undersigned hereby acknowledges his/her responsibility under applicable Federal law and the Agreement between _____ and University of Miami Hospital, to keep confidential any information regarding Hospital patients, as well as all confidential information of Hospital. The undersigned agrees, under penalty of law, not to reveal to any person or persons except authorized clinical staff and associated personnel any specific information regarding any patient and further agrees not to reveal to any third party any confidential information of Hospital, except as required by law or as authorized by Hospital.

Dated this _____ day of _____, 20__.

_____
Print Program Participant Name (Student)

Witness: _____

_____
Signature Program Participant (Student)