Faculty/Instructor Form

Date:_____

_____

Last name First Name MI

Address: _____

_____

Phone: _____ Gender: ☐Yes ☐No

Email: _____ Date of Birth:_____

Do you have a license number: ☐Yes ☐No If yes, attached copy of license: ☐Yes ☐No

Have you taught/trained at San Francisco General Hospital before: ☐Yes ☐No

If yes, date(s):_____ Department:_____

Affiliated School

Please only include the applicable degree for what you will be instructing.

School Name:_____ School City/State:_____

Area of Study/Practice:_____

Type of Degree:_____

Course Title:_____ # of Credits/Units:_____

Approved School: ☐Yes ☐No Approved Program: ☐Yes ☐No *If **no** for either, please contact your preceptor/SFGH contact or the Department of Education & Training @415.206.4655. **Do not** proceed until further notice.*

Start Date:_____ End Date: _____ Course objectives attached: ☐Yes ☐ No ☐ N/A

*Please complete **only** if you are not the school contact.*

School Contact Name: _____

*Title:*_____ *Department:*_____

School Contact Email: _____ *Phone:*_____

*School Contact License Number (if applicable):*_____

Instruction Role

SFGH Department/Clinic/Unit	Responsibilities/Course	Schedule/Shift

Signature of a San Francisco General Hospital (SFGH) employee or preceptor named below indicates the student and instruction arrangements have been agreed upon by both parties. Preceptor is the SFGH contact and the signature below indicates the needs for faculty/instructor campus access.

Preceptor Name :_____ Signature:_____

Preceptor Email:_____ Preceptor Phone:_____

Health Requirements

*Faculty/Instructors are **required** to provide proof of immunizations, screenings and/or titers of below BEFORE starting placement. Although not required, we strongly recommend Hepatitis B screening and vaccination. For clinical faculty/instructors, health screening is required at the beginning of every clinical rotation. Complete below and show proof to the preceptor/SFGH staff. Actual records are not needed; do not attach.*

Health Screening Records	Date(s)	
Rubeola (Measles): Vaccinated or Titers showing immunity		
Rubella (German Measles): Vaccinated or Titers showing immunity		
Varicella: Vaccinated or Titers showing immunity		
Mumps: Vaccinated or Titers showing immunity		
Tuberculosis: PPD negative or chest x-ray negative (within one year and 3 months of projected start date, two tests total)	**1 year**	**3 months**
Proof of Hepatitis B (not required)		
Seasonal Flu (flu season only)*		

**Contact the Department of Education & Training to see if it is an active flu season. Typically the flu season is from Fall through Winter.*

Emergency Contact

Please provide a contact person in case of an emergency while on the San Francisco General Hospital campus or affiliated clinics.

Name: _____

Relationship: _____

Phone #1: _____ Phone #2: _____

Oath of Confidentiality

As a condition of clinical placement, conducting research, a student internship or the observation of patient care at San Francisco General Hospital and Trauma Center, I _____, agree not to divulge any information obtained in the course of such training or research to unauthorized persons, and not to public or otherwise make public any information regarding persons who have received services such that the person who received services is identifiable.

I further agree not to divulge or public general patient information or statistics without prior authorization from my preceptor or hospital administration.

I further agree to hold in strict confidentiality all matters discussed in Medical Staff of hospital committee meetings to which I might be privy.

I recognize that the unauthorized release of confidential information may make me subject to civil action under provisions of the Welfare and Institutions Code.

Signature:_____ Date:_____

Faculty/Instruction Declaration

I certify that the information provided on this form is true, accurate and complete. I agree to provide the immunization/screening records upon the hospital's request. I understand that any false information will cause my disqualification in any programs on the San Francisco General Hospital (SFGH) campus and affiliated clinics. I recognize that all confidential information obtained or observed at SFGH is in confidential nature. I agree, that at all times, to ensure the confidentially of all sensitive information I have contact with, comply with applicable laws and maintain patient privacy. I understand that failure to comply with any of the above requirements may result in cancellation of my instruction agreement. I further attest that I have received appropriate written material and introduced to the hospital and the appropriate department/unit/clinic protocol and standards.

Signature:_____ Date:_____

Submission

Submit forms addressed to Student Placements (scanned forms are acceptable as original documents):

Mail: Department of Education and Training
San Francisco General Hospital and Trauma Center
1001 Potrero Avenue, Bldg 30, Suite 3200
San Francisco, CA 94110

Email: akilah.cadet@sfdph.org

Fax: 415.206.4450 Phone: 415.206.4655

Department Use Only—Received Date:_____ Initials:_____