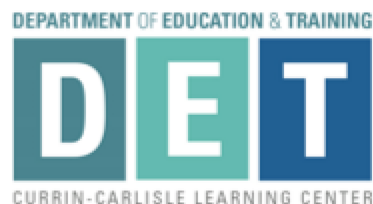

Single Preceptor Nursing Student Placement Form

Name

First Name ________ Middle Name ________ Last Name ________

Date

Month ____ Day ____ Year ____

Date of Birth (MM/DD/YYYY)

____

Gender

____

Address

Street Address ________

City ________ State ________

Zip Code ________

Phone Number

____

E-mail

____

Do you have a Professional License number?

Yes

No

If yes, please type "attached" and provide a copy of Professional License

____

Have you been placed as a student at ZSFG before:

Yes

No

If yes, please indicate the Date and Department ____________

Education

Only include applicable degree for student placement experience

---

School Name

____

School Address

____________ City

____________ State

Area of Study/Practice

____

Type of Degree

____

1. Approved School

Yes

No

2. Approved Program

Yes

No

3. Start Date

____ Month ____ Day ____ Year

End Date

____ Month ____ Day ____ Year

4. Evaluation for Student Required

5. Hours/Time Required

If yes, what is the requirement (hrs./wks)

____

6. Course Title

____

7. Total # of Credits/Units

____

8. School Contact Name

First Name Last Name

Title:

School Contact E-mail

Phone Number

9. Course Objectives attached

Yes

No

n/a

10. Student contract attached

Yes

No

n/a

Precepting Department/Unit

1. Department/Unit

2. Student Schedule/Shift

3.Department specific Students Responsibilities

4. Preceptor Name

5. Preceptor E-mail

6. Preceptor Phone Number

Preceptor Signature

Health Requirments

Students are required to provide proof of immunizations, screening and/or titers of below BEFORE starting placement. Although not required, we strongly recommend Hepatitis B screening and vaccination. For clinical students, health screening is required at the beginning of every clinical rotation. Complete below and show proof to the preceptor/ZSFG STAFF. Actual records are not needed; do not attach.

Provide Date(s) for the following:

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

Rubeola (Measules)

____
Vaccinated or Titers showing Immunity

Rubella (German Measles)

____
Vaccinated or Titers showing Immunity

Varicella

____
Vaccinated or Titers showing Immunity

Mumps

____

Seasonal Flu

____
Flu season only

Tuberculosis

____
PPD negative/chest x-ray negative (within 1 yr.& 3 months of projected start date, two tests total)

Emergency Contact

Please provide a contact person in case of an emergency while on the Zuckerberg San Francisco General Hospital (ZSFG) campus or affiliated campus

---

Name

________________ ________________________
First Name Last Name

Relationship

____

Phone Number 1

____

Phone Number 2

____

Health Data Access

In addition to completing below, the preceptor must complete the Invision/LCR Request form and the student must complete the Online User Confidentiality and Security Agreement (forms available on the DPH intranet)

---

1. Health data access needed

Yes (If yes, continue below)

No (If no, proceed to next section)

2. Reason for request

____

3. By checking off the box(s) below you are confirming that you have read and understood each of the applicable policy

I understand and agree that it is my legal and ethical responsibility to maintain the confidentiality of all patient medical records and the patient information they contain.

I understand that ZSFG conducts random routine audits of who gains access to medical record without a direct need to know.

I understand and agree that the records must not be removed from the Health Information Systems Department for any reason.

I have received and reviewed the Health Insurance Portability and Accountability Act (HIPAA)

Oath of Confidentiality

As a condition of clinical placement, conducting research, a student internship or the observation of patient care at Zuckerberg San Francisco 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 resources 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 on all matters discussed on Medical Staff or 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 Codes.

Signature

____

Date

_____ Month _____ Day _______ Year

Orientation

I attest that the above named student has been orientated to the hospital by completing online based orientation via Litmos Learning Management System. He/she has been introduced to Department/Unit/Clinic specific standards and protocols.

Preceptor Name

____________ __________________
First Name Last Name

Date

____ ____ ______
Month Day Year

Preceptor Signature

____

Dept/Unit

____

Student 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 Zuckerberg San Francisco General Hospital (ZSFG) campus and affiliated clinics. I recognize that all confidential information obtained or observed at ZSFG 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

____ ____ ______
Month Day Year

Submission

Submit form addressed to (electronic submission preferred and accepted as original): Mail: Janet Kosewic, Nursing Professional Development Zuckerberg San Francisco General Hospital and Trauma Center, 1001 Potrero Avenue, 7th Floor, 7G40 San Francisco, CA 94110 Email: janet.kosewic@sfdph.org Fax: 415.206.6922 Phone: 628.206.4191