# MEDICAL STUDENT INFORMATION FORM

Please provide the following information regarding your last Advocate rotation:
Site: _____ ☐ This is my first
Rotation: _____ rotation at an
End Date: _____ Advocate site.

(Please indicate with an X, the Advocate site where you will be rotating)

☐ Advocate Medical Group Office ☐ Good Samaritan Hospital ☐ Lutheran General Hospital
☐ Christ Medical Center ☐ Good Shepherd Hospital ☐ Trinity Hospital
☐ Condell Medical Center ☐ Illinois Masonic Medical Center

**PLEASE PRINT!**

## MEDICAL STUDENT DEMOGRAPHICS

| Last Name | First Name | Middle | Date of Birth (Month/Day/Year) | Gender | Social Security No. (last 5 digits only) |
|---|---|---|---|---|---|
| | | | ___/___/___ | ☐ M ☐ F | ___-_____ |

| Name of Rotation | Rotation Dates (start and end) | Type of Rotation | Name of Preceptor |
|---|---|---|---|
| | | ☐ Clerkship ☐ Sub-I ☐ Elective ☐ Other | |

| Current Street Address | City | State/Zip | Cellular Phone No. | Home Phone No. |
|---|---|---|---|---|
| | | | | |

| Primary E-mail | Secondary E-mail | License Plate No./State | Scrub Size (small-XXL) |
|---|---|---|---|
| | | | |

## MEDICAL EDUCATION

| Medical School & State | Expected Graduation Date | Year in Medical School for scheduled rotation |
|---|---|---|
| | | ☐ M1 ☐ M2 ☐ M3 ☐ M4 |

## IN CASE OF EMERGENCY

| Name of Local Friend or Relative | Relationship to Medical Student | Cellular Phone No. | Home Phone No. | Work Phone No. |
|---|---|---|---|---|
| | | | | |

X _____ _____
Department/Program Approval ( If Applicable) Date

Received by Medical Education Dept. _____

Revised 2/14

# First Net

## CC ms Care Connection - MEDICAL/PA Student/APN

*(Please print and write legibly. The Bold and * items are required)*

***Hospital, Choose one only:**

☒ **Christ** ☐ **Good Sam** ☐ **Shepherd** ☐ **Condell** ☐ **Masonic** ☐ **Trinity** ☐ **South Sub** ☐ **Lutheran**

***Name:** _____ _____ _____
(Last) (Middle) (First)

***Last 5 SSN #:** _____ ***AdvocateOne ID:** _____ School: _____

Start Date: ____/____/____ ***End Date:** ____/____/____
*(Assumed ASAP if no date)* *(Assumed one month from the time received if no date)*

***Confidentiality Agreement:***

As a non-employee of Advocate Health Care, you or your representatives may have access to patient, medical record, employee or other confidential information. As a condition to being granted such access, you are required to agree to the following:

I understand that in the course of my working relationship with Advocate Health Care, I share the responsibility of maintaining the confidentiality of any patient, medical record or employee information that I may have available to me. I understand that it is my responsibility to follow Advocate Health Care policies and procedures as they relate to the assurance of patient rights and the confidentiality of information both written and verbal.

Computer Systems: I understand that I may receive a unique User-Id and a personal password necessary for me to gain access to an Advocate Health Care computerized system. I understand and agree that both the User-id and my Password are for my own personal use and are not to be disclosed to or used by third parties. If at any time I feel that the confidentiality of my User-id or password has been compromised, I will contact appropriate management (Advocate employee that approved your access) for direction within 24 hours.

Conduct and Confidentiality: I understand that I must maintain the confidentiality of any written or oral patient, medical record or employee information that I have access to or view as a result of my working relationship with Advocate Health Care. I understand that the release of patient, medical record or employee information of any kind is only allowed by Advocate Health Care policy guidelines. If I am uncertain or do not understand the Advocate Health Care policy guidelines, I will contact the appropriate Advocate manager (Advocate employee that approved your access) for assistance and direction within 24 hours. I agree to only release patient, medical record or employee information under the Advocate Health Care policy guidelines or as required by law.

Patient, Medical Records and Employee Information: I acknowledge that all information involving patients, medical records and employee information is private and confidential. I agree that I shall access only that data necessary for the proper performance of my job responsibilities under my business relationship with Advocate Health Care. I further agree to keep confidential any and all information that I access, receive or transcribe, and not to disclose any such information to third parties. I am aware, that, unless specifically identified as part of my job by "Advocate Health Care", I am not authorized to discuss any information concerning a patient's or employee's personal data or medical condition. I am responsible for ensuring that discussions regarding patient, medical record and employee information are held in appropriate locations with only authorized individuals.

Any unauthorized disclosure on my part or my representatives will be a very serious offense to Advocate Health Care. Such unauthorized disclosure may result in Advocate's repossession of all of my or my representative's access to patient, medical record and employee information, Advocate may also act up to and including termination of my business relationship with Advocate and asserting its full rights under the law.

***Student Signature** _____ Date _____

### Access Required and Corresponding CareConnection Position:

☒ **Emergency Medicine Medical Student or Physician Assistant Student** = ED Medical Student w/Documentation

☐ **Medical Student or Physician Assistant Student without ability to enter orders** = Medical Student

☐ **Medical Student or Physician Assistant Student with ability to enter orders** = Medical Student w/Order Entry

☐ **Inpatient APN Student** = APN

☐ **ED APN** = ED Advanced Practice Nurse

***Does this student require access to psychiatric *(confidential)* units?** ☒ **YES** ☐ **NO**

If yes, please explain: _____

**Authorized by:** *(Please make sure all of the above are correct)* *(Upon receipt please allow 3 to 4 business days to complete this request)*

**Print Name:** _____

**Title/Dept:** _____ **Phone #:** _____

_____ **Date:** _____
**(**Authorizing Signature**)**

*Scan completed form and send by email (secadmin@advocatehealth.com) or fax (630-575-5395 c/o IS Security)*

( ↓ For Information Systems Security Administration Use Only ↓ )

Completed by: _____ Date: _____

**ADVOCATE HEALTH CARE MEDICAL EDUCATION**
**STUDENT/RESIDENT MEDICAL & IMMUNIZATION CLEARANCE FORM**

***This form must be completed in its ENTIRETY and on file 4 weeks before the rotation start date.***

Name: _____ SSN:(last 5 digits) _____

Address: _____
Street City, State Zip Code

Phone: _____ DOB ___/___/___ College/Univ./Sponsor Hosp.: _____

AHC Hospital/Rotation: _____ Rotation Dates: _____

**REQUIRMENTS**

**TB Surveillance**:

a.) Skin Testing: Last TB skin test **OR** Quantiferon (QFT) test must be done **WITHIN ONE CALENDAR YEAR OF THE ROTATION END DATE.** Skin test result MUST be read in mm of induration.

b.) If TB skin test **OR** QFT is/was POSITIVE, the student MUST attach a copy of a negative CXR report. In addition, if a student/resident has had a positive TB screening in the past he/she MUST attach a copy of the Advocate annual screening questionnaire completed within one year of the rotation start date.

DATE of last TB skin test: _____ RESULT in mm: _____

DATE of last QFT: _____ RESULT: _____

**TB Mask Fit Testing**: Required prior to rotation start date; must be specific for the mask(s) listed
**Required Brand: Halyard/ KC Tecnol Fluid Shield PFR95 N95 Particulate Filter Respirator**
TB Mask Fit Test Date: ____/____/____ Size (circle one): Regular/Model #46767 or Small/Model #46867

**Immunization Record:**

***Circle Results***

**Rubella Immunity Status**
Rubella Titer: Date____/____/____ Result: Immune / Non Immune - or
Proof of Vaccination: Date # 1 ____/____/____ # 2 ____/____/____

**Rubeola Immunity Status**
Rubeola Titer: Date ____/____/____ Result: Immune / Non Immune - or
Proof of Vaccination: Date # 1 ____/____/____ # 2 ____/____/____

**Mumps Immunity Status**
Mumps Titer: Date ____/____/____ Result: Immune / Non Immune - or
Proof of Vaccination: Date # 1 ____/____/____ # 2 ____/____/____

**Varicella Immunity Status**
Varicella Titer: Date ____/____/____ Result: Immune / Non Immune - or
Proof of Vaccination: Date # 1 ____/____/____ # 2 ____/____/____

**Hepatitis B Immunity Status**
Hepatitis B AB Titer: Date ____/____/____ Result: Positive / Negative
Hepatitis B Vaccination: Date #1____/____/____ # 2 ____/____/____ # 3 ____/____/____

**Tetanus/Diphtheria/Pertussis (Tdap):** Date vaccinated ____/____/____

**Flu Vaccine**: Current flu season vaccine required prior to rotations occurring between 10/1 and 4/30. Date vaccinated ____/____/____

The information provided on this questionnaire is accurate to the best of my knowledge. I understand and agree that any misrepresentation or omissions may be justification for denial of student/resident privileges. I authorize Advocate Heath Care to verify any information contained in this health history.

Signature_____ Date_____

**Please return this form to the appropriate personnel of the Hospital Department/Program where you will be rotating.**

**Effective 6/2018**

Email form to Emmanuel@fcvalet.com prior to the start of your rotation.

Place bottom section (Student Parking Permit) on your dashboard any time you are parked on the campus property for the duration of your rotation.

Advocate
Christ Medical Center
Tomorrow starts today.

NAME: _____

Rotation Start Date: _____ Rotation End Date: _____

Vehicle Make: _____ Model: _____

Color: _____ License Plate No. _____

Cell Phone No. _____

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Advocate
Christ Medical Center
Tomorrow starts today.

# STUDENT PARKING PERMIT

ROTATION START DATE:_____

ROTATION END DATE: _____

This permit must be displayed and visible at all times while parked on campus.

STUDENT PARKING IS LOCATED IN ASSOCIATE LOTS 2, 3 AND 4 ON THE EAST SIDE OF THE HOSPITAL

Only needed if history of positive PPD

# TB TEST/HEALTH HISTORY QUESTIONNAIRE
## Advocate Occupational and Employee Health Centers

Name_____ SS#_____ Date ____/____/____
(please print)

Facility: ***Advocate Christ Medical Center*** Dept Rotating With: DOB____/____/____

**REASON FOR SCREENING** *(Test or Questionnaire)*

☐ Pre-Placement ☐ Initial Exposure ☐ Post Exposure Follow-up
☐ Annual / Semi-annual ☐ Post Exposure Baseline ☐ Other _____

**FIT TESTING** *(for those who have been fit tested for the TB mask)*

Since your last fit test for the TB mask or respirator, check all that apply which may have altered the fit of your mask:

☐ New scarring on face (injury or surgery
☐ Significant weight loss or gain (over 10 lbs.)
☐ Have grown a beard or mustache
☐ Neurologic deficit (Bell's palsy, stroke)
☐ Facial fracture (nose, jaw, cheek)
☐ Have obtained dentures
☐ Plastic surgery on face
☐ No Change

**Rotating Associate Signature** *(required)*: _____

**PPD TESTING**

Have you taken steroids or chemotherapy in the past 6 weeks? ☐ Yes_____ ☐ No

People who have the following diseases are considered to have a positive TB skin test if induration is 5 mm or greater in size.
Have you been diagnosed as having any of the diseases listed below? Check all that apply.

☐ Diabetes ☐ Cancer ☐ Alcoholism
☐ Silicosis ☐ Hodgkin's ☐ Malabsorption Syndrome
☐ Immune Deficiency ☐ Renal Disease ☐ Recent Gastrectomy

| | Date Applied | Lot# | Applied by | Site | Date Read | (mm induration) | Read by |
|---|---|---|---|---|---|---|---|
| 1st step | ____/____/____ | _____ | _____ | ☐R ☐L | ____/____/____ | _____mm | _____ |
| 2nd | ____/____/____ | _____ | _____ | ☐R ☐L | ____/____/____ | _____mm | _____ |

***TB test must be read by the Employee Health Center or a TB Liaison 48 to 72 hours after test is placed.***

**TB HEALTH HISTORY QUESTIONS** *(For those with history of positive TB reaction, record the following history but DO NOT RETEST! For follow-up questionnaires only complete section 3.)*

| | Yes | No | Don't Know | |
|---|---|---|---|---|
| 1. | ☐ | ☐ | ☐ | Have you ever had a positive TB test? If yes, when_____ |
| | ☐ | ☐ | ☐ | Have you ever been treated with INH to prevent TB? If yes, for how long? _____ |
| | ☐ | ☐ | ☐ | Have you ever received the BCG vaccine? |
| | ☐ | ☐ | ☐ | Have you ever had an abnormal chest x-ray? When? _____ |
| 2. | | | | |
| | ☐ | ☐ | ☐ | Have you ever been told you have Infectious Tuberculosis? If yes, how long ago? |
| | ☐ | ☐ | ☐ | Have you ever been treated with medication for Infectious TB? |
| | ☐ | ☐ | | Did you take all the TB Medicine until the physician told you that you were finished? |
| *3. | ☐ | ☐ | | Do you currently have a cough that has lasted longer than three weeks? |
| | ☐ | ☐ | | Do you cough up blood or mucous? |
| | ☐ | ☐ | | If yes, have you recently had the mucous you cough up tested for TB? |
| | ☐ | ☐ | | If yes, were you told it was positive? |
| | ☐ | ☐ | | Have you had a decrease in your appetite? Aren't hungry? |
| | ☐ | ☐ | | Have you lost weight (over 10 pounds) in the last 2 months without trying? |
| | ☐ | ☐ | | Do you have night sweats (need to change the sheets or your clothes because they are wet)? |
| | ☐ | ☐ | ☐ | Do you live with or have you been in close contact with someone who was recently diagnosed with TB (e.g. roommate, close friend, relative)? |
| | ☐ | ☐ | | Have you been diagnosed with Infectious TB since completing your last TB questionnaire? |