2018-19 OhioHealth Dublin Methodist Hospital
Family Medicine Elective Rotation Student Application

Thank you for choosing OhioHealth Dublin Methodist Hospital to be a part of your educational experience.

APPLICATION PROCESS

Directions: Please be sure to thoroughly read and complete every section of this application. Do not submit this application to OhioHealth until all of the additional items listed in **Section C** of this application have been secured. Once you have all of the additional items, everything including this application should be submitted via email as one complete package to the Dublin Methodist Medical Education Department, at DublinFamilyMedicine@OhioHealth.com. **Incomplete applications will not be processed.**

Applications must be received a minimum of 30 days prior to the 1st requested rotation date.

Applications will be evaluated in the order they are received. You will be notified within two weeks of submission. **Please allow 10 business days before contacting the program for a response.**

Once your completed application is approved and you are notified by the Dublin Methodist Medical Education Department, dropping the rotation should only be done in extreme cases. If such circumstances arise that require you to drop the rotation, please contact the Medical Education Manager, Sandi Miller, at sandi.miller@ohiohealth.com.

OhioHealth
BELIEVE IN *WE*™

2018-19 OhioHealth Dublin Methodist Hospital
Family Medicine Elective Rotation Student Application

Date: _____ **School:** _____

SECTION A: Applicant Information

Name: _____
Last First MI

Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: (_____) _____ E-Mail Address: _____

SSN: _____-_____-_____ **DOB:** ____/_____/_____

Emergency Contact: _____
Name Phone

Previous OhioHealth Rotations

- ❑ I have rotated in a previous OhioHealth hospital.
  Locations and dates of previous OhioHealth rotations: _____
  Student OPID: _____ OhioHealth ID Badge Number: _____
- ❑ I have completed OhioHealth student CareConnect (EPIC) training.
  Location: _____ Date: _____
- ❑ I have completed OhioHealth student online OhioHealth University Courses.
  Date: _____
- ❑ This is my **FIRST** OhioHealth rotation.

Reason for Request

Please explain your reason for requesting this rotation.

Why are you interested in this 4th year Family Medicine elective? _____
_____
_____

Why are you interested in completing this Family Medicine elective in Dublin? _____
_____
_____

Please describe your post-residency dream practice: _____
_____
_____

Requested Rotation Dates

Please select up to three choices and number them in order of preference.

- ❑ July 30-August 26, 2018
- ❑ August 27- September 23, 2018
- ❑ September 24-October 21, 2018
- ❑ October 22-November 18, 20187
- ❑ November 19-December 16, 2018
- ❑ December 17, 2018-January 13, 2019

SECTION B: School Information

Program Coordinator/Contact Name: _____
Last First MI

Email Address: _____ **Phone:** (____) _____

- ❑ My school has a current Affiliation Agreement with OhioHealth.
- ❑ My school does not have a current Affiliation Agreement with OhioHealth.

  ***Please note – applications will not be considered without a current Affiliation Agreement.**
- ❑ I'm not sure if my school has a current Affiliation Agreement with OhioHealth.

SECTION C: Required Additional Items

The items listed below must be submitted along with this application.

- ❑ Copy of USMLE or COMLEX Step 1 score report
- ❑ Copy of USMLE Step 2CK or COMLEX Step 2CE score report (if not available, please indicate date of exam_____)
- ❑ Copy of current (i.e. unexpired) ACLS card
- ❑ Signed Confidentiality Statement of Understanding and Internet User Agreement (attached)
- ❑ Current CV

SECTION D: Student Acknowledgement

I acknowledge that during my clinical experience at any OhioHealth facility, I will receive, generate, consider and use information which is confidential in nature. I understand that the unauthorized dissemination of confidential information would be harmful to OhioHealth and/or to the patients or others served by OhioHealth facilities. I agree to maintain the confidentiality of such information and not to discuss the same except as permitted by OhioHealth policy and applicable law.

With the completion of this application, it is understood that, if appointed, I will abide by the rules and regulations set forth by OhioHealth and/or its affiliated hospitals. I will faithfully perform the assigned duties to the best of my ability for the full period of my appointment, unless I am relieved from said duties by OhioHealth and/or its affiliated hospitals.

Signature: _____ **Date:** _____

Printed Name: _____

Submit completed application and materials to Dublin Methodist Medical Education at DublinFamilyMedicine@OhioHealth.com.

Confidentiality Statement of Understanding and Internet Use Agreement

This statement summarizes the responsibilities and obligations of all persons who use, create or receive confidential information through any affiliation with OhioHealth, as set out in OhioHealth's Privacy Policy. This statement further serves to inform workforce members of the expectations and responsibilities regarding appropriate internet use when representing OhioHealth or utilizing OhioHealth resources. The scope of this statement covers all OhioHealth "workforce members" defined to include (but not limited to): employees, volunteers, trainees, contractors, employed physicians (including residents), non-employed physicians, and associated staff that may access OhioHealth confidential information for patient care or healthcare operations, and other persons whose conduct, in the performance of work for OhioHealth, is under the direct control of OhioHealth, whether or not the person is paid by OhioHealth.

I understand and acknowledge that:

- It is my legal and ethical responsibility to protect the privacy, confidentiality, and security of all confidential or sensitive information including, but not limited to, Protected Health Information (patient-identifiable information) and Health Care Business Information such as proprietary business, associate, or provider information.
- I will not, at any time during or after my employment or affiliation with OhioHealth, improperly use, disclose to any person, or store any confidential information, nor will I permit any unauthorized person to examine or make copies of any reports, documents, or on-line information that comes into my possession. Confidential information is made available on a need to know basis and is limited to the minimum necessary requirement, and thus, I will not access confidential information without authorization, and I will do so only when I am required to do so for specific business purposes.
- Unauthorized disclosure of confidential information is totally prohibited.
- Disclosure of or sharing of passwords, access codes, and hardware token devices assigned to me (my "Access Credentials") is prohibited. I am accountable for my Access Credentials and for any improper access to information gained through use of my Access Credentials. My Access Credentials are the equivalent of my legal signature, and I shall take all reasonable and necessary steps to protect my Access Credentials. I am responsible for all actions taken using my Access Credentials. If I have reason to believe that the confidentiality of my Access Credentials or the confidentiality of my staff's credentials has been broken, I shall immediately notify the OhioHealth Director of Information Security.
- If I utilize a personal electronic device to access confidential information, I will ensure that all confidential information accessed through the device will be afforded the protections required by federal, state, and local laws and regulations. It is my responsibility to apply the required and indicated technical, physical, and administrative safeguards to such devices. Such safeguards include but are not limited to: encryption, password protection, anti-virus software, not leaving my devices unattended, and locking and logging off the device after my use. Further guidance on such safeguards can be found in OhioHealth Policies and Procedures.
- OhioHealth assumes no responsibility for the use, maintenance, support, or potential damages that may be incurred with any personal devices used to access OhioHealth confidential information.
- If a personal device used to access Protected Health Information is lost or stolen, I will immediately report such incident to the OhioHealth Privacy Officer at 866-411-6181 or via mycompliancereport.com (Access ID: OHH).
- Internet access and use on an OhioHealth network should be limited to business purposes, and personal use should be minimized. Inappropriate activity includes but is not limited to: utilizing an OhioHealth internet connection for activities that are not directly related to a business purpose of OhioHealth; activities that are illegal or intended to circumvent applicable laws and regulations; activities that could lead to accusations of unethical behavior or damage OhioHealth's professional reputation.
- I will immediately report any suspicious activity (e.g. unexplained appearances of new files, corrupted files, access by unauthorized staff, and access to inappropriate websites) or any computers that are suspected of being compromised by malicious attack to the OhioHealth Director of Information Security.
- I will not divulge confidential information to unknown sources without proper identification, authorization, and confirmation of identity.
- I understand that I may use "cloud" applications and servers (such as Evernote and Dropbox) only for educational purposes and presentations I am giving. In conjunction with my use of cloud applications, I may not use, upload, or share (i) any Protected Health Information or (ii) any confidential and proprietary business information of or from OhioHealth; and that I will not, at any time, identify OhioHealth Corporation as the source of such information.
- If I violate any of the above statements, I may lose my access privileges immediately and may be subject to corrective actions up to and including termination.

By signing below, I acknowledge I have read and understand the foregoing information, and I agree to comply with the above terms.

_____ _____

Signature **Date**

_____

Print Name (First, MI, Last)