University of Florida College of Medicine – Jacksonville
Visiting Student Application Checklist

NAME:_____ **ROTATION:**_____

DATES:_____ **HOME SCHOOL:**_____

Do you need housing while rotating in Jacksonville? _____ YES _____ NO
*****Housing is not guaranteed to visiting students, but we will make every effort to accommodate your request*****

EMERGENCY CONTACT INFORMATION

Name_____ **Phone**_____

Address_____

****Do NOT submit your application until all items have been completed****
Incomplete applications will not be considered – Submission Instructions on page 2

Students: Initial in each blank to certify each document has been completed and included in your application

_____ Application for Extramural Course
_____ Required Health Record
_____ Liability Confirmation Form
_____ Background and Drug Screen Affidavit
_____ HIPAA Training Certificate
_____ UF Confidentiality Statement
_____ Shands Confidentiality Agreement
_____ Parking Application*
_____ Copy of vehicle registration*
_____ CV/Resume
_____ USMLE Step 1 Scores (MD/DO only)

* If you plan to rent a vehicle, you may submit this document at check-in

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FOR OEA USE ONLY – STUDENTS: DO NOT WRITE BELOW THIS LINE

Application Received _____ Sent to Department _____

Contract Obligations _____ Insurance: SIP EX AI

Dorm: No Yes / Invoice

_____ Enter Applicant in NI _____ Application uploaded to NI _____ Computer access sent to student & coordinator

NOTES

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE –JACKSONVILLE
APPLICATION FOR EXTRAMURAL COURSE

Mail Application to:
Office of Educational Affairs
c/o Student Administrator
653-1 W. 8th Street, Box L-15
Jacksonville, FL 32209

Medical Student Administrator
Kelsey Kyne (904) 244-5128 Kelsey.Kyne@jax.ufl.edu
Medical Student Coordinator
Karen Sisco (904) 244-8233 Karen.Sisco@jax.ufl.edu
Fax Numbers (904) 244-8997 OR (904) 244-4771

This form must be filled out completely – no substitute will be accepted – and must include the completed Required Health Record Section (page 2) before any rotation request will be considered.

PART 1 (to be completed by student)

Name: _____ Phone number: _____

Address: _____

Email address: _____ Name of school: _____

Course for which application is made: _____

Requested dates: _____ to _____ Second Choice dates: _____ to _____

During this course, student will be in year _____ of a _____ year program. Degree to be obtained _____

Signature of student: _____ Date: _____

PART 2 (to be completed by Dean of Students or comparable official where student is enrolled)

The student above is in good standing and approved to take this course YES_____ NO_____ Initials_____

Student personal health insurance is in effect during the period indicated. YES_____ NO_____ Initials_____

The student has been instructed in safety measures and infection control precautions. YES_____ NO_____ Initials_____

The student has passed a local, state, and national criminal background check on: DATE_____ Initials_____

The student has passed an official random drug screen for common substances of abuse on: DATE_____ Initials_____

The student will have completed all required core clerkships prior to this rotation (please list):

_____ Initials_____

Name of Official: _____ Title: _____

Email: _____ Phone: _____

Signature _____ Date: _____

PART 3 (to be completed by University of Florida College of Medicine-Jacksonville)

This rotation is { } approved { } not approved by: (course sponsor signature) _____ Date_____

Student is to report to: (person/place) _____

on: (date and time) _____ Contact phone: _____

Associate Dean for Student Affairs Final Approval:

Signature _____ Date: _____

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE –JACKSONVILLE
REQUIRED HEALTH INFORMATION RECORD

Please type or print legibly. This form must be filled out completely – no substitute will be accepted – and must be accompanied by a completed Application for Extramural Course before any rotation request will be considered.

PART 4 (to be completed by student)

Name: _____

Date of Birth: _____ Last 4 of Social Security Number (required):_____

DO NOT SEND IMMUNIZATION RECORDS IN PLACE OF THIS FORM
Failure to complete this form in its entirety will delay the approval process.

All students must answer the following questions to determine his/her immunization status in order to meet the measles and rubella requirement of the Florida Board of Regents. If any answer is "YES", then follow the instructions at the right. If all answers are "NO", then proceed to Part 5.

		If "Yes" then:
Born before January 1, 1957?	Yes / No	Rubella only required
Had confirmed measles or rubella?	Yes / No	Provide documentation
Had a blood test proving immunity?	Yes / No	Provide documentation
Documentation: attach physician letter, or titer results		Rubella Titer Date_____ Results _____
		Measles Titer Date_____ Results _____

PART 5 (to be completed by Physician, School, Public Health Clinic or comparable official where student is enrolled)
REQUIRED IMMUNIZATIONS Date in mm/dd/yyyy format

Measles (one dose at 12 months of age or older and in 1968 or later) _____

Measles booster (second dose one month or more after first dose) _____

Rubella (one dose at 12 months of age or older and in 1968 or later) _____

Tdap (within the last 5 years) _____

Hep B Titer Date_____ Results_____ OR Immunization #1 Date _____
Immunization #2 Date _____
Immunization #3 Date _____

Varicella Titer Date_____ Results_____ OR Immunization #1 Date _____
Note: History of varicella (chicken pox) is not sufficient Immunization #2 Date _____

PPD (within 12 months of the rotation start date, attach results of other testing) Date _____
Results (in mm) _____

I have reviewed the records available, and to the best of my knowledge the above named student has been adequately immunized against measles and rubella as required by the Board of Regents, State University System of Florida, as well as the other required immunizations and testing as above.

Name of Official: _____Title:_____

Signature _____Date:_____

OEA Use only

Immunizations Complete_____ **Immunization Deficiencies_____**

UF UNIVERSITY of FLORIDA

College of Medicine - *Jacksonville*
Office of Educational Affairs

653-1 West 8th Street
4th Floor, LRC Box L15
Jacksonville, FL 32209
904-244-3149
904-244-4771 Fax

Professional Liability Insurance Verification for Visiting Students

*****Students: this form is to be completed by an official at your home institution*****

I certify that (name of student) _____

is in good standing at (name of school) _____

and has received my approval to participate in the following rotation at the UF College of Medicine

Name of Rotation _____ Dates _____

During the student's participation, the following applies to professional liability coverage (select one):

1. ☐ The student's home institution is a State of Florida Public University and is protected without charge per the UF Self Insurance Program policies*

2. ☐ The University of Florida Board of Trustees will be added as an additional insured with the policy of the home institution with limits of not less than $1,000,000/$3,000,000.

3. ☐ The student will be responsible for purchasing additional insurance through the University of Florida Self Insurance Program at a fee of $100.00 per rotation. Payment is due prior to the rotation start date and must be in the form of a check made payable to "UF Self Insurance Program".

Signature _____ Title_____

Printed Name _____ Date _____

School _____ Phone Number _____

Email _____ Fax _____

Mailing Address _____

*State Universities, set forth in s. 1000.21(6), Florida Statutes are: University of Florida; Florida State University; Florida Agricultural and Mechanical University; University of South Florida; Florida Atlantic University; University of West Florida; University of Central Florida; University of North Florida; Florida International University; Florida Gulf Coast University; New College of Florida

College of Medicine - *Jacksonville*
Office of Educational Affairs

653-1 West 8th Street
4th Floor, LRC Box L15
Jacksonville, FL 32209
904-244-5128
904-244-8997 Fax

AFFIDAVIT

I (Name of Student) _____,

of (Address) _____

Swear or affirm the following:

1. I have had no incidents of criminal behavior since the local state background check that was completed and confirmed on

DATE _____
(month/day/year)

2. I have had no incidents of criminal behavior since the national background check that was completed and confirmed on

DATE _____
(month/day/year)

3 . I have not taken any illegal substances since the drug screen that was completed and confirmed on

DATE _____
(month/day/year)

I understand that I am obligated to notify the University of Florida College of Medicine of any incidents of criminal behavior or drug use prior to or during my requested rotation. I further understand that the University of Florida College of Medicine has the right to remove me from my requested rotation at any time.

Sworn to and subscribed before

me this (Day)_____ day of (Month)_____, (Year)_____

Signature of Notary_____ Signature of Student _____

Rotation Name & Dates: _____

UF HIPAA Training Information & Instructions

The UF Health Science Center - Jacksonville and Shands Jacksonville have established policies concerning the confidentiality of patient and hospital information. All individuals observing at the Jacksonville campus are required to become familiar with these policies by completing a HIPAA training program. This program will be included in annual student orientations for University of Florida students.

Individuals from other institutions are required to complete UF's online HIPAA training program prior to the start of the experience. The directions are as follows:

1. Go to http://privacy.health.ufl.edu/
2. On the left side of the page, underneath "Training", select "HIPAA for Visitors & Vendors"
3. At the bottom of the page, select "Begin HIPAA at UF"
4. The slide presentation will begin – review each slide and enter answers where requested
5. **Register at the end & print certificate or save as PDF**

- If you have a UF ID#, please use it
- If you have not been assigned a UFID, use ####-0000, where the first 4 digits are a set of numbers that means something to you, such as part of a phone number, address, or zip code. **Please do not use all 0's!**
- If you have a UF ID# but can't remember it, go to: What's My UFID?

Browsers and Pop-Up Blockers

The training is best accessed through Internet Explorer (IE). It will sometimes work with other common browsers, but be advised that other browsers as well as MacIntosh and Linux systems tend to give it extreme indigestion and the slides will be distorted. You will need to use a different computer, preferably a PC running IE.

The training module appears as a pop-up box. If you click below on Begin HIPAA & Privacy and get sent back to this page, you may have a "Pop-Up Blocker" installed. Disable the blocker or use a different computer that allows pop-ups from this page. Speak to your computer support person, if necessary, for help.

Thank you for your participation. If you have any questions, please read this entire page first. Then, if you don't find the answer you need, contact Kelsey.Kyne@jax.ufl.edu

UNIVERSITY OF FLORIDA

Confidentiality Statement

- I acknowledge that this statement applies to all members of the workforce, including but not limited to, employees, volunteers, students, physicians, resident physicians, and third parties, whether temporary or permanent, paid or not paid, visiting, or designated as associates, who are employed by, contracted to, or under the direct control of the medical components of the *University of Florida* (UF). The medical components include the Health Science Centers located in both Gainesville and Jacksonville, and all their direct support organizations, designated as *affiliated entities* (affiliates) in the Privacy Manual of the University of Florida.

- I acknowledge that UF has formally stated in the UF Privacy Manual its commitment to preserving the confidentiality and security of health information, whether it is maintained or distributed in paper, electronic, video, verbal, or any other medium or format. I understand that I am required, if I have access to such health information, to maintain its confidentiality and security.

- I understand that access to health information created, received, or maintained by UF or its affiliates in any location is limited to those who have a valid business or medical need for the information or otherwise have a right to know the information. I understand that there are many administrative, physical and technical safeguards in place to protect the privacy and security of this health information, and that any attempt to bypass or override these safeguards is a violation of federal and state laws and the privacy and security policies of the University of Florida.

- I understand that anyone who is authorized to access electronic health information within UF and affiliate systems will be issued a unique user identification and password, and that any person who knowingly discloses their user ID or password to others, uses or discloses another individual's user ID or password, or accesses any electronic protected health information without authorization is subject to disciplinary action, up to and including dismissal. In addition, I understand that all UF and affiliate workforce members must comply with applicable Information Technology Security Policies.

- I understand that approved methods and purposes for access to, uses and disclosures of, and requests for, any and all protected health information created, received or maintained by UF and its affiliates are limited to those described in the *University of Florida* Privacy Manual policies and procedures. I further understand that, with the exception of purposes related to treatment, access to, uses and disclosures of, and requests for an individual's health information must, to the extent practicable, be limited to the minimum necessary to accomplish the intended purpose of the approved use, disclosure or request.

- I understand that any known or suspected violation of the confidentiality or security of health information must be reported to my immediate supervisor or to the Privacy Officer immediately.

I have read the UF Confidentiality Statement and I understand that violation of this policy may result in disciplinary action, up to, and including, dismissal, by the University or its health care affiliated entities, in accordance with UF policies, UFJPI/UFJHI policies, and Rules 6C1-1.008, 6C1-3.047, 6C1-4.016, and 6C1-7.048 of the Florida Administrative Code, as applicable.

I have read the University of Florida Health Information Policy.

Print Name		Signature
Date	UF ID # NOT APPLICABLE FOR VISITING STUDENTS	College/Dept NOT APPLICABLE FOR VISITING STUDENTS

Confidentiality Statements are required annually (within every 12 months). Signed documents are placed in the personnel, student, or other appropriate file of the signer. Confidentiality Statements "signed" on-line may be printed and filed as previously stated or stored on-line.

SHANDS
HealthCare

Confidentiality and Security Agreement

Shands HealthCare (SHANDS) has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their personal health information. Additionally, SHANDS must protect the confidentiality of organizational information that may include, but is not limited to, human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information from any source or in any form including, without limitation, paper, magnetic or optical media, conversations, and film. For the purpose of this Agreement, all such information is referred to as "Confidential and Protected Information." In the course of my employment / association / affiliation with SHANDS, I understand that I may have access and / or exposure to Confidential and Protected Information.
I UNDERSTAND AND HEREBY AGREE THAT:

1. I will access and / or use SHANDS Confidential and Protected Information only as necessary to perform my job-related duties and in accordance with SHANDS' policies and procedures.
2. My User-ID and password are confidential, and in certain circumstances may be equivalent to my **LEGAL SIGNATURE** and I will not disclose them to anyone. I understand that I am responsible and accountable for all entries made and all information accessed under my User-ID.
3. I will disclose Confidential and Protected information only to authorized individuals with a need to know that information in connection with the performance of their job function or professional duties.
4. I will not copy, release, sell, loan, alter, or destroy any Confidential and Protected Information except as properly authorized by law or SHANDS policy.
5. I will not discuss Confidential and Protected Information so that it can be overheard by unauthorized persons. It is not acceptable to discuss information that can identify a patient in a public area even if the patient's name is not used.
6. I will only access and / or use systems or devices I am authorized to access / use, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
7. I have no expectation of privacy when using SHANDS information systems. SHANDS has the right to log, access, review, and otherwise use information stored on or passing through its systems, including e-mail.
8. I will never connect to unauthorized networks through SHANDS systems or devices.
9. I will practice good workstation security measures such as never leaving a terminal unattended while logged in to an application, locking up diskettes when not in use, using screen savers with activated passwords appropriately, and positioning screens away from public view.
10. I will practice secure electronic communications by transmitting Confidential and Protected Information in accordance with approved SHANDS security standards.
11. I will:

    a. Use only my assigned User-ID and password.
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
    d. Not attempt to learn or use another's User-ID and password.
12. Upon termination of my employment / affiliation / association with SHANDS, I will immediately return or destroy, as appropriate, any Confidential and Protected Information in my possession.
13. Violation of this Agreement may result in disciplinary action, up to and including termination of employment / affiliation / association with SHANDS, suspension and / or loss of medical staff privileges in accordance with the SHANDS policies.
14. Unauthorized or improper use of SHANDS information systems and / or Confidential and Protected Information, is strictly prohibited and may not be covered by SHANDS' insurance or my personal professional malpractice insurance. **Any such violation may subject me to personal liability as well as sanctions for violation of state and federal law.**
15. I will notify my manager, Shands IT Security Officer, or other appropriate Information Services personnel if my password has been seen, disclosed, or otherwise compromised.
16. My obligations under this Agreement will continue after termination of my employment / affiliation / association with SHANDS.

By signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Signature _____ Date _____

Printed Name _____ Employee Number NOT APPLICABLE FOR VISITING STUDENTS

Entity NOT APPLICABLE FOR VISITING STUDENTS
(ie, Shands Jacksonville , UF Physicians, College of Medicine, etc.)

Department NOT APPLICABLE FOR VISITING STUDENTS License # NOT APPLICABLE FOR VISITING STUDENTS

SHANDS
Jacksonville
Parking Application

FOR OFFICIAL USE ONLY:
CC#: _____
Bill Code: _____
Zone: _____

Please note: A copy of your **CURRENT VEHICLE REGISTRATION** is required in order to receive your parking pass and decal. No parking passes or decals will be issued absent this information.

DATE (dd/mm/yyyy):_____
CARDHOLDER NAME:_____
STUDENT NAME:_____

UFID #_____ _____
COLLEGE:_____ TYPE OF STUDENT:_____
HOME ADDRESS:_____
_____
CELL PHONE:_____ HOME PHONE:_____

1ST VEHICLE	2ND VEHICLE	3RD VEHICLE
MAKE:	MAKE:	MAKE:
MODEL:	MODEL:	MODEL:
COLOR:	COLOR:	COLOR:
PLATE #:	PLATE #:	PLATE #:
SHANDS DECAL #:	SHANDS DECAL #:	SHANDS DECAL #:

SIGNATURE: _____

FOR OFFICIAL USE ONLY:

ISSUE DATE: _____CARD#_____

NOTES:_____
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Revised 4/28/08 ec