Saint Agnes Medical Center
A Member of Trinity Health

Instructor Clearance Packet

- You are responsible to maintain your eligibility for attending a clinical rotation at SAMC. You will not be allowed to participate in clinicals at SAMC if your immunizations or other requirements are expired

- Review the following documents:
  - Faculty/Student Orientation User Guide
  - NURSING Students/Instructors only: SAMC Nursing Resource Packet
  - Orientation Validation Quiz
  - HSTM Modules and EPIC training if seeking access to EPIC

- Submit all required signed documentation to Nursing.Education@samc.com email no later than July 1st of each year.
  - Annual Instructor Competency Validation
  - Acknowledgement Form (for Orientation Quiz and PPE Requirements)
  - Confidentiality and Network Access Agreement

- Other requirements and information prior to coming for clinical rotations:
  - School ID Badges are to be always worn and visible
  - Syllabus and schedule/roster of students sent to the manager before the first day on the floor
  - You or your school designee submits all student requirements no less than 3 weeks prior to the start of the rotation. All of these documents have been reviewed and verified by a school designee to be current and accurate. Delays may occur do to incomplete or inaccurate information recorded.
  - Authorized parking for students and instructors is in front of c-Care across Herndon. Carpooling and walking to the medical center in packs is recommended.
  - All instructors and students must enter the facility through the Outpatient visitor entrance in the North Wing
  - Pre-post conferences are permitted with approval of unit manager

Keep this page for your reference

SAINT AGNES MEDICAL CENTER
Instructor/Student Requirements Summary

Name:
Institution:
Date:

This summary sheet indicates competencies completed by students attending clinical rotations at the Medical Center. Criteria for evaluation of each competency are kept on file in Clinical and Professional Development Department.

IP = In person training T= Test/Quiz/Module R= Received/Reviewed RD= Return Demonstrate S=Submit Signed Form

Requirements	Validation Methods	Verified by Nursing Education
Read and Review Faculty/Student Orientation User Guide/Complete Quiz	R, T	
Read and Review SAMC Resource Guide (Nursing ONLY)	R	
Required Annual Instructor Competency Validation	R/T/RD/S	
HSTM Modules and EPIC In Person Training if Applicable	IP/T Indicate NA if applicable	
Confidentiality and Network Access Agreement	R, S	
Signed Summary and Acknowledgement for Orientation Quiz **Nursing ONLY: SAMC Resource Packet**	R, S	

My signature below indicates I have completed the exercises and reviewed the information and/or policies.
I understand I am accountable for this information and responsible to incorporate this information in my clinical experience at SAMC.

Signature: _____ Date: _____

Required Annual Instructor Competency Validation
HOUSEWIDE: Nursing School Instructors: New and Returning

School Instructor Name:
Institution:
Date:

This summary sheet indicates required annual precepted clinical orientation checklist to be completed by nursing school instructors supervising students at the Medical Center.

T= Test/Quiz R= Received/Reviewed RD= Return Demonstrate S=Submit Signed Form

Activity / Skill	Validation Method	Date Completed:
NEW: 12 hours orientation **RETURNING**: 4 hours refresher orientation	Observation and RD	
Perform two medication administrations with ICARE and side effects	RD	
Participate in at least one Hand Off of Care using SBAR	RD	
Perform one Quality Control (QC) or Patient Test on NOVA Glucose Meter	RD	
Scavenger Hunt on Unit	RD	
EPIC Review Assessments & Flowsheets Hester Davis Broset I & O Etc. Orders Progress Notes Care Plan Diagnostic Results & Reports (Lab/Radiology/etc.)	R/RD	

Signature of Preceptor:_____ Date: _____

Preceptor Print Name:_____ Unit: _____

Trinity Health

Trinity Health Confidentiality and Information Security Agreement

SIGNATURE PAGE / RELATIONSHIP TO TRINITY HEALTH / MINISTRY ORGANIZATION

I am a: (Please Check all that apply)

Direct relationship w/ Saint Agnes Med Center

___Colleague (employee) at (MINISTRY Name)
___Physician Credentialed on (MINISTRY Name) Medical Staff
___Volunteer at a (MINISTRY Name) Facility
___Temporary/Contractor at a (MINISTRY Name)/ Facility: (name of agency)
✓ ***Student/Instructor at **Saint Agnes Medical Center: (name of educational organization)*** _____

Employed by or associated with a (MINISTRY Name) Credentialed Medical Staff Member

___Medical Staff Member's Employee or Temp Staff (name of practice) _____
__-Medical Staff Member's Vendor's Employee (name of vendor)_____

Vendor Providing Goods or Services to (MINISTRY Name)

___Employee/Temp Staff of (MINISTRY Name)'s clinical services vendor: (name of vendor)
___Employee/Temp Staff of (MINISTRY Name)'s business services vendor: (name of vendor)
___Employee/Temp Staff of (MINISTRY Name)'s IT services vendor: (name of vendor)

(MINISTRY Name)'s Joint Venture or a Facility Managed by (MINISTRY Name)

___Employee of a (MINISTRY Name)'s Joint Venture (name of joint venture:) _____
___Employee of a Hospital/Other Facility Managed by (MINISTRY Name) (name of facility):_____
___Credentialed Physician on Medical Staff of a Hospital/Other Facility Managed by (MINISTRY Name):
(Name of facility):_____
___Employee or Temp Staff of a Credentialed Physician on the Medical Staff of a Hospital/Other Facility Managed by (MINISTRY Name): (name of physician's practice)

Other

___Unaffiliated (non-credentialed) Physician/Other Provider: (name of practice) _____
___Employee of an Unaffiliated Physician or Facility: (name of practice or facility) _____
___Employee of a Payer :(name of payer)
___Researcher (Research study name):_____
___Other (name of employer) _____

**USER SIGNATURE

If there are any items in this agreement that I do not understand, I will ask the Director in the Development and Support Services Department for clarification. My signature below acknowledges that I have read, understand and accept this agreement and realize it is a condition of my employment or association with Trinity Health. I also acknowledge that I have received a copy of this Confidentiality and Network Access Agreement.

Date: _____

Print Name:_____/ Signature:_____

EMPLOYER SIGNATURE

(**Required** when user is an employee or agent of: a physician/physician practice; other individual or facility provider; a vendor that is not a business associate; any other organization unaffiliated with (MINISTRY Name) or Trinity Health.
My signature below acknowledges that I have read, understand and accept my responsibilities as the employer or the sponsor of the user who has signed this agreement above.

Print Name:_____Date:_____

Signature of employer of the individual to be given access:_____

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Acknowledgment Form

I have read and reviewed:

- Faculty/Student Orientation User Guide/Quiz
- Saint Agnes Resource Packet (Nursing ONLY) *

I understand this information is what informs me of the safety and regulatory items required to work in the healthcare facility I am assigned. It also informs me of the personal protective equipment required. I know I am responsible for and agree to abide by the information contained within the user guide and from the other information provided. I also understand that I have am informed of the specific parking requirements for SAMC.

*If I am a nursing student or instructor, I have read the SAMC Resource Packet and understand the additional requirements for patient care within the nursing division. I understand that I may contact the department manager or educator if I have any questions.

I have completed the faculty/student orientation quiz and have submitted the test to my instructor or advisor.

_____/_____
Print Name Signature

_____/ _____
School Date