



Saint Agnes Medical Center
A Member of Trinity Health

Student 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 only: SAMC Nursing Resource Packet
- Submit all required signed documentation to your instructor
 - Student Requirements Summary
 - Acknowledgement Form (for Orientation Quiz)
 - 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
 - Ongoing PPE and screening requirements are in place
 - Must perform self-attestation for no symptoms prior to coming for clinical
 - Do NOT come if any symptoms present
 - Must enter at Patient Registration Entrance (East side behind Emergency)
 - Surgical mask and eye protection recommended but NOT required for all patient facing situations
 - Being fully vaccinated and boosted is required
 - Approved exemptions are required for non-vaccinated individuals
 - No COVID testing is currently required
 - 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 north wing Outpatient Testing entrance
 - No gathering on campus for pre-post conferences is permitted

Keep this page for your reference



**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: _____

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.

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

Requirements	Validation Methods	Verified by Clinical Instructor or School Designee
Read and Review Faculty/Student Orientation Guide/Complete Quiz	R, T	
Read and Review SAMC NURSING Resource Packet (Nursing ONLY)	R	
Confidentiality and Network Access Agreement	R, S	
Signed Summary and Acknowledgement for Orientation Quiz and 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: _____

