MONROE COUNTY HOSPITAL
Human Resources Checklist for
Students/Interns/Physician Extenders

Name: ___________________________ Dept: ___________________________

Start Date: _______________ Initial Schedule: __________________________

Supervisor: ______________________ Contact Number: _________________

Completed/Provided by Student:
☐ Student Volunteer Application
☐ Confidentiality Statement
☐ Health Assessment Form
☐ Respiratory Protection Program Screening Questionnaire
☐ Bloodborne Pathogen Classification Sheet
☐ Copy of current Drug Screen
☐ Copy of current Criminal Background Check
☐ Copy of current liability insurance coverage
☐ Copy of current TB Skin Test
☐ Copy of current license (if applicable)
☐ Immunizations
☐ Orientation
   ☐ Review Orientation
   ☐ Watch required videos
   ☐ Take test
   ☐ Sign acknowledgement forms

Verified by Human Resources:
☐ OIG Exclusion List
☐ Orientation
   ☐ Ensure each individual understands

I certify that the above information has been explained to me in detail and I understand
the rules and regulations of Monroe County Hospital.

_________________________________________  __________________________
Signature                                      Date

_________________________________________  __________________________
Human Resources Signature                      Date
Monroe County Hospital
Student Volunteer Application

Name: ____________________________________________
   Last       First       MI

SSN: ___________________________     DOB: ___________________________

Address: _______________________________________________________

City: ___________________________     State: _______     Zip: __________

Phone: ___________________________     Secondary Phone: __________

Please complete your educational history:

<table>
<thead>
<tr>
<th>School</th>
<th>Name &amp; Address</th>
<th>Year Graduated</th>
<th>Degree</th>
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Please complete your work history:

Employer: ___________________________     Dates of Employment: __________

Address: ___________________________     Phone: _________________________

Supervisor: ___________________________     Reason For Leaving: __________

Job Title: ___________________________     Duties: ________________________
Employer: ___________________ Dates of Employment: ________________
Address: ___________________ Phone: ____________________________
Supervisor: ___________________ Reason For Leaving: ________________
Job Title: ___________________ Duties: ____________________________

Employer: ___________________ Dates of Employment: ________________
Address: ___________________ Phone: ____________________________
Supervisor: ___________________ Reason For Leaving: ________________
Job Title: ___________________ Duties: ____________________________

List any clinical licensure or registration (CPR, ACLS, etc.):
____________________________________________________________________
____________________________________________________________________

List any professional, trade, business, or civic activities and offices held:
____________________________________________________________________
____________________________________________________________________

Specialized Skills:
☐ Personal Computer
☐ Fax Machine
☐ Word Processing Software: ________________________________
☐ Spreadsheet Software: ________________________________
☐ Other: ________________________________________________
Professional References (Do not list family members)

Name: ___________________________ Phone: ___________________________
Address: __________________________

Name: ___________________________ Phone: ___________________________
Address: __________________________

Name: ___________________________ Phone: ___________________________
Address: __________________________

Student Volunteer Statement:

I certify that the information given in this application is true and complete to the best of my knowledge. I understand that this application is subject to the review and approval of Monroe County Hospital management. I further understand that my relationship, if approved, with Monroe County Hospital will be that of an unpaid volunteer and I will be subject to complete supervision by the hospital manager to whom I am assigned. Although I will not be an employee of the hospital, I realize that I will be expected to abide by the rules, regulations, and guidance set for by Monroe County Hospital. I also understand that my participation in a volunteer learning program can be terminated at any time that Monroe County Hospital deems necessary.

______________________________  _________________________
Signature of Applicant          Date
MONROE COUNTY HOSPITAL

CONFIDENTIALITY STATEMENT

I understand and agree that in the performance of my duties as a student/intern/physician extender of Monroe County Hospital, that I am obligated to maintain all information concerning a patient confidential, both on duty and off duty.

Furthermore, I understand that a violation of these confidentiality considerations will result in disciplinary action and may result in loss of my position. I further understand that I could be subject to legal action.

By signing below, I acknowledge that I have read and understand the above statement.

Print Name

Signature Date
Monroe County Hospital  
Post Offer Health Assessment

Name: ____________________________  DOB: ____________________

Address: ______________________________________________________

Primary Phone: ____________________  Secondary Phone: ______________

Male: ___  Female: ___  Martial Status: ___  Race: _______________________

Social Security No.: ____________________  Position: __________________

Notify in case of emergency: __________________

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Have you ever had or have now (check all that apply):

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<th>Condition</th>
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1. List any conditions which you have that is not listed above:

____________________________________________________________________________
____________________________________________________________________________

2. When was the last time you received a Tetanus Toxoid injections? ______________

3. Have you ever had Hepatitis B vaccination? Yes: _____ No: _____ Date: __________

4. (Employees born after 1957). Have you received two Measles vaccinations? Yes: _____ No: _____

5. List all drug or substances to which you are allergic and specify type of reaction, such as itching, wheezing, swelling, etc.
   1. ______________________________________________________________________
   2. ______________________________________________________________________
   3. ______________________________________________________________________
   4. ______________________________________________________________________

6. Are you receiving medical treatment at this time? Yes: _____ No: _____
   If yes, give reason: ______________________________________________________________________
   Physician in charge: ______________________________________________________________________

7. List all medications you are now taking.
____________________________________________________________________________
____________________________________________________________________________

8. List any operations, serious illness, or injuries that you have had.
____________________________________________________________________________
____________________________________________________________________________

9. Do you have any scars? Yes: _____ No: _____ If yes, describe: _______________________

10. Have you ever been injured on the job? Yes: _____ No: _____
    Who was your employer and what is the approximate date of injury?
    a). ______________________________________________________________________
    b). Name and address of physician: ______________________________________________________________________
    c). What part of body was injured? ______________________________________________________________________
    d). Did you receive Workers' Compensation benefits? Yes: _____ No: _____
    e). Did you receive any permanent disability? Yes: _____ No: _____
f). Have you ever been given physical restrictions by a physician? Yes: _____ No: _____
   If yes, describe: _______________________________________________________________

g). Do you have any current work restrictions? Yes: _____ No: _____
   If yes, describe: _______________________________________________________________
   If yes, are your restrictions permanent: Yes:______ No: ________

11. Have you ever had any problems with your back? Yes: _____ No: _____
    If yes, describe (give date and details including names of treating physicians):
    _______________________________________________________________________

12. Do you wear glasses? Yes: _____ No: _____ Approximate date of last eye exam?
    _______________________________________________________________________

14. Do you smoke? Yes: _____ No: _____ How many per day? ________________

I submit this information and to the best of my knowledge it is complete and correct. I hereby permit this information that relates to my job to be made available to management for proper job placement.

_________________________________________  ________________
Signature                                      Date
Monroe County Hospital
Infection Control Department
Respiratory Protection Program Screening Questionnaire
(OSHA form CFR 1910.134 App C)

To the employer: Answers to questions in Section 1, and through question 9 in Section 2 of Part A do not require a medical examination:

To the Employee: Can you read (circle one): Yes/No

Your employer must allow you to answer this questionnaire during normal working hours or at a time and place that is convenient to you. To maintain your confidentiality, your supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by everyone who has been selected to use any type of respirator (please print).

1. Today's date: ____________________________ 2. Your name: _______________________________________

3. Your age (to nearest year): __________ 4. Sex (circle one): Male/Female


7. Your job title and department: __________________________

8. A phone number where you can be reached by the health care professional who reviews the questionnaire (include the area code): __________________________

9. The best time to phone you at this number: __________________________

10. Has your employer told you how to contact the health care professional who will review the questionnaire (circle one): Yes/No   Jean Riley, RT, ext 249.

11. Check the type of respirator you will use in your job. (You can check more than one category)
   a. __________ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   b. __________ other type (for example, half- or full-facepiece type, powered-air purifying, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No   If “yes”, what type(s): __________________________

Part A. Section 2. (Mandatory) Questions 1 through 9 below, must be answered by every employee who has been selected to use any type of respirator. Please circle “yes” or “no”.

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month? Yes/No

2. Have you ever had any of the following conditions?
   1. Seizures (fits): Yes/No
   2. Diabetes (sugar disease): Yes/No
   3. Allergic reactions that interfere with you breathing: Yes/No
   4. Claustrophobia (fear of closed-in places): Yes/No
   5. Trouble smelling odors: Yes/No

3. Have you ever had any of the following pulmonary or lung problems?
   1. Asbestosis: Yes/No
   2. Asthma: Yes/No
   3. Chronic bronchitis: Yes/No
   4. Emphysema: Yes/No
   5. Pneumonia: Yes/No
   6. Tuberculosis: Yes/No
   7. Silicosis: Yes/No
   8. Pneumothorax (collapsed lung): Yes/No
   9. Lung cancer: Yes/No
   10. Broken ribs: Yes/No
   11. Any chest injuries or surgeries: Yes/No
   12. Any other lung problem that you've been told about: Yes/No
4. Do you currently have any of the following symptoms of pulmonary or lung illnesses?
   1. Shortness of breath: Yes/No
   2. Shortness of breath when walking fast on level ground or walking up a slight incline: Yes/No
   3. Shortness of breath when walking with other people at an ordinary pace on level surface: Yes/No
   4. Have to stop for breath when walking at your own pace on level ground: Yes/No
   5. Shortness of breath when washing or dressing yourself: Yes/No
   6. Shortness of breath that interferes with your job: Yes/No
   7. Coughing that produces phlegm (thick sputum): Yes/No
   8. Coughing that wakes you early in the morning: Yes/No
   9. Coughing that occurs mostly when you are lying down: Yes/No
   10. Coughing up blood in the last month: Yes/No
   11. Wheezing: Yes/No
   12. Wheezing that interferes with your job: Yes/No
   13. Chest pain when you breath deeply: Yes/No
   14. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you ever had any of the following cardiovascular or heart problems?
   1. Heart attack: Yes/No
   2. Stroke: Yes/No
   3. Angina: Yes/No
   4. Heart failure: Yes/No
   5. Swelling in your legs or feet (not caused by walking): Yes/No
   6. Heart arrhythmia (heart beating irregularly): Yes/No
   7. High blood pressure: Yes/No
   8. Any other heart problem that you've been told about: Yes/No

6. Have you ever had any of the following cardiovascular or heart symptoms?
   1. Frequent pain or tightness in your chest: Yes/No
   2. Pain or tightness in your chest during physical activity: Yes/No
   3. Pain or tightness in your chest that interferes with your job: Yes/No
   4. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
   5. Heartburn or indigestion that is not related to eating: Yes/No
   6. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you currently take medication for any of the following problems?
   1. Breathing or lung problems: Yes/No
   2. Heart trouble: Yes/No
   3. Blood pressure: Yes/No
   4. Seizures (fits): Yes/No

8. If you've used a respirator, have you ever had any of the following problems? (If you have never used a respirator, check the following space and go to question 9):
   1. Eye irritation: Yes/No
   2. Skin allergies or rashes: Yes/No
   3. Anxiety: Yes/No
   4. General weakness or fatigue: Yes/No
   5. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Reviewed by: ___________________________ Date: ________________
Employee Job Classification Sheet for Potential Exposure To Blood Borne Pathogens

Based on your job description and the duties assigned to you, please place a check by the job classification that best matches your position.

___ Level III Exposure: Minimal risk – Little or no patient contact, or contact with contaminated items. Risk primarily related to the fact that I work in a health care environment. No use or contact with sharps. (Clerk, Manager, Medical Records, etc)

___ Level II Exposure: Medium risk – Casual contact with patients or support services. Occasionally uses sharps. (handles lab specimens, transports patients).

___ Level I Exposure: High risk – Works with patients, exposed to blood or other agents in large volume frequently or for long periods of time. Frequent use of sharps. (nurses, lab techs, xray techs, housekeeping, maintenance)

I understand my risk to blood borne pathogens and have had the opportunity to ask questions related to the risk.

___________________________________________  _______________
Employee Signature                          Date
MCH Personnel Policies

1. Are you required to wear your MCH ID badge at all times?
   a. Yes
   b. No

2. When do you receive your first evaluation?
   a. 90 days after employment.
   b. 1 year after employment.
   c. Whenever your supervisor thinks it is necessary.

3. What are the guidelines for an accident/incident?

The Core Values:

1. What core value is the first and most important?
   a. Person
   b. Caring
   c. Integrity
   d. Quality

2. Why are Core Values so important?
   a. Because my grandmother has these values.
   b. Because we act the way we think and believe.
   c. Because I’ll look foolish if I don’t know them.

Quality Management Program:

1. The goal of quality improvement is to:
   a. Study why other departments are causing problems with patient care.
   b. Continuously work with the physicians to improve nursing care.
   c. Continuously study and adapt functions and processes within the hospital to achieve improved patient care and services outcomes.

2. What model/process is utilized by MCH in our cycle of quality improvement?
   a. PDCA – Process, Determine, Cause, Analyze
   b. PDCA – Plan, Do, Check, Act
   c. PCDA – Performance, Develop, Communicate, Associate
3. A performance improvement team uses this quality tool to give them a visual representative of all the various causes that contribute to a single effect.
   a. Control Diagram
   b. Fishbone Diagram
   c. Task Diagram

**Patient Safety Test:**

1. MCH uses two patient identifiers; name and date of birth, when:
   a. Administering Medications
   b. Administering blood products
   c. Taking blood samples and other specimens for clinical testing.
   d. providing any other treatment or procedures.
   e. All of the above.

2. Only the clinical staff at MCH need to be involved in the Patient Safety Program?
   a. True
   b. False

3. MCH is involved with a statewide patient safety effort with the Georgia Hospital Association called PHA – which stands for:
   a. Public Health Activity
   b. Partnership for Health and Accountability
   c. People’s Health Administration
   d. Peach Health Act

**Infection Control Test:**

1. The best way to prevent the spread of infection is by:
   a. Washing your hands.
   b. Staying away from people.
   c. Keeping your eyes closed.
   d. Not talking.

2. The location of our TB room is:
   a. in the ER.
   b. Room 274.
   c. In the hallway.
   d. In the Maintenance Department.

3. Our exposure control plan:
   a. Tells you what to do if you fall.
   b. Details your paycheck.
   c. Tells you what to do if you are stuck by a needle or splashed by blood or OPIM.
Health Care-Associated Infection and Hand Hygiene Improvement Test

1. Adequate handwashing with water and soap requires:
   a. 5 minutes
   b. 20-30 seconds
   c. 40-60 seconds

2. Hands are the most common vehicle to transmit health care-associated pathogens?
   a. True
   b. False

3. Why is it important to wash your hands?
   a. Protect the patient against harmful germs carried on your hands or present on his/her own skin.
   b. Protect yourself and the health-care environment from harmful germs.
   c. An infection can cause a prolonged stay in the hospital or even death.
   d. All of the above.

Safety Management Test:

1. The code for Security is Code Grey?
   a. True
   b. False

2. A urine drug screen must be done if an employee has an accident?
   a. True
   b. False

3. How many surveys does the Safety Committee conduct each year?
   a. One
   b. Two
   c. Three

MRI Safety Test:

1. The magnet is only one when a MRI is being done?
   a. True
   b. False

2. All metal is prohibited in MRI?
   a. True
   b. False
**Privacy Test:**

1. The Privacy Rule does not allow the hospital to use PHI to carry out hospital operations.
   a. True
   b. False

2. The “Minimum Necessary Rule” allows employees to access PHI needed to accomplish their jobs?
   a. True
   b. False

3. The hospital must implement reasonable safeguards to limit incidental disclosures?
   a. True
   b. False

**HIPAA Security Test:**

1. HIPAA is the first state law passed to protect the privacy and security of patient’s health information?
   a. True
   b. False

2. EPHI is Electronic Protected Health Information?
   a. True
   b. False

   a. True
   b. False

4. Network access is available to all hospital employees?
   a. True
   b. False

5. Employees are not required to report potential security violations; that is the responsibility of the Security Officer.
   a. True
   b. False
Compliance Test:

1. You shouldn’t report compliance issues because you may lose your own job doing so?
   a. True
   b. False

2. It isn’t important to report compliance problems because nothing will be done about it anyway.
   a. True
   b. False

3. The “EMTALA” law requires every emergency room patient to receive an adequate medical screening prior to being asked about payment?
   a. True
   b. False

4. It is a compliance problem if procedures/medications administered to the patient are not properly documented in the chart?
   a. True
   b. False

5. Compliance issues can cost the hospital a lot of money?
   a. True
   b. False

Customer Service Test:

1. What is the MCH Motto?

2. Who is our competition?
   a. The Medical Center of Central Georgia.
   b. Anyone the customer compares our organization to.
   c. The hospitals in Atlanta.

Cultural Sensitivity Test:

1. List three (3) examples of diversity.

2. What is Culture?

3. What are the four (4) barriers to accepting others?
Emergency Preparedness Test:

1. There are six (6) components of NIMS?
   a. True
   b. False

2. We must be in compliance with NIMS to receive federal assistance and grants after a disaster or emergency?
   a. True
   b. False

3. NIMS compliance involves a series of activities aimed at improving institutional preparedness and integration with a community-based response system?
   a. True
   b. False

4. Your department director can grant permission to leave the premises during or after an emergency or disaster?
   a. True
   b. False