Office of Nursing Recruitment
2014-15
High School Career Awareness Work Shops
University of Rochester Medical Center

Time: 0800 AM-11:30 AM

Nursing Career Awareness Workshops

October 22, 2014 Rm 2-7536

November 12, 2014 Rm 2-7536 "Men In Nursing"

December 10, 2014 Rm 2-7544

February 11, 2015 Rm- TBD

April 22, 2015 Rm – TBD

Learn about the Career of Nursing, Talk to a guest Panel of Nurses from different areas of Nursing, & take a tour of In-patient Units.

Please contact Lisa Beckford at Email address:
Lisa_Beckford@URMC.rochester.edu 585-273-4794

Student Paper work must be completed in its entirety to be considered for placement in workshop. Fax form to: 585-756-5882 Attn: Lisa Beckford

Grades 9-12 (must be 16 years old)

Nurse Recruitment and Marketing

601 Elmwood Avenue- Box 619-19

Rochester NY 14642

MEDICINE of THE HIGHEST ORDER

UNIVERSITY of ROCHESTER MEDICAL CENTER

Strong Memorial Hospital
Golisano Children's Hospital at Strong
(585) 275-3478

Office Of Nurse Recruitment

Application for Health Career Awareness Workshop 8a-11:30a

Career Awareness Workshop Date (number in order of preference)

__ **October 22, 2014**

__ **November 12, 2014- "Men in Nursing"**

__ **December 10, 2014**

__ **February 11, 2015**

__ **April 22, 2015**

ATTACHMENT: Form 1

Nursing Practice
Nursing Recruitment/Marketing and Retention
601 Elmwood Ave – Box 619-19
Rochester, NY 14642
Lisa Beckford, RN, BSN
Phone: (585) 273 – 4794 FAX: (585) 756 – 5882

APPLICATION FORM & EMERGENCY CONTACT(S)

TO BE COMPLETED BY STUDENT

Check "1" Box To Indicate The Experience You Are Applying For: Date:_____

☐ Shadowing ☐ Career Awareness Workshop ☐ Internship

Student Name:_____ Student Signature:_____
(please print)

Address:_____ E-Mail:_____

Check Appropriate Box To Indicate Your Level In School: ☐ Middle School Student Record Grade Level: _____
☐ High School Student

Preferred Day(s) of Week: _____ Preferred Time(s): _____am / pm
[Monday – Friday ONLY]

Please explain why you are requesting this experience: _____

_____

_____

TO BE COMPLETED BY PARENT/ GUARDIAN *PRIMARY EMERGENCY CONTACT*

Date: _____

Parent/Guardian Name:_____ Parent/Guardian Signature:_____
(please print) (if student is a minor)

Address:_____ E-Mail:_____
[ONLY If different than student's address]

Contact Phone Number(s) *DAY*: _____ *EVENING:* _____

2nd EMERGENCY CONTACT

Name:_____ Relationship:_____
(please print)

Contact Phone Number(s) *DAY*: _____ *EVENING:* _____

TO BE COMPLETED BY SCHOOL COUNSELOR

School:_____

School Counselor: _____ Contact Phone Number: _____
(please print)

I have received the Parent/Guardian Emergency Notification Sheet:_____
School Counselor Signature

IMPORTANT: This completed form must be returned to the address at the top of this form with a Confidentiality Form and a completed Certificate of Health & Immunization Requirements form with proof of all immunizations [see ATTACHMENT Form 3. ALL FORMS must be completely filled out, signed and dated.

TO BE COMPLETED BY NURSING RECRUITMENT/MARKETING AND RETENTION

INITIALS: _____

Date(s) of Experience: _____ Time(s) of Experience: _____am / pm
_____ _____am / pm
_____ _____am / pm

Location of Experience: _____ URMC Employee Name: _____

Approved: Nursing Recruitment/Marketing & Retention 1/21/14
Nursing Practice Executive Committee 1/21/14
Original Disseminated: 3/6/14
Reviewed:
Revised:

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ATTACHMENT: Form 2

Nursing Practice
Nursing Recruitment/Marketing and Retention
601 Elmwood Ave – Box 619-19
Rochester, NY 14642
Lisa Beckford, RN, BSN
Phone: (585) 273 - 4794

STUDENT CONFIDENTIALITY AGREEMENT & RULES

Check "1" Box To Indicate Which Experience You Are Applying For:

☐ Shadowing ☐ Career Awareness Workshop ☐ Internship

Strong Memorial Hospital has a legal and ethical obligation to safeguard the privacy of all patients and to protect the confidentiality of their health information. While participating in your shadowing or short-term educational experience, you may have access to confidential patient information and it is important that you keep this information confidential. Strong Memorial Hospital requires you to sign this confidentiality statement to ensure that you understand your obligations to keep patient information confidential.

1. I understand that federal and state laws and regulations require that patient information be kept strictly confidential, and that this includes information that is spoken, written or in a computerized format. These laws and regulations require that patient information be accessed, used and disclosed only on a need-to-know basis. This applies to any information at all about a person's physical or mental health and the fact that they received healthcare, and even basic information such as the patient's name or where they live.
2. I agree that I will keep all patient information confidential and will use it only while I am at Strong Memorial Hospital and for the reasons I am present in the hospital. This means, among other things, that:
   a. I will not access confidential patient information that I have no reason to access or know, for example, by reading any part of a patient's medical record without being told to do so by an appropriate hospital representative; and
   b. I will not discuss any patient information with any person except as part of the shadowing or educational program in which I am participating at the hospital.
3. I am aware that the possession or use of alcohol and other drugs, fireworks, guns and other weapons is prohibited.
4. I understand that I may not leave university property or the program without permission of the Program Sponsor
5. I am aware that the use of tobacco products is prohibited.
6. I understand that misuse, damage or theft of property is prohibited. I understand that charges will be assessed against those participants who are responsible for damage, theft or misuse of university property.
7. I understand that I must follow all safety rules in accordance with university standards and/or as defined by the program administrator.
8. I understand that the University will not be responsible for any injury to me while participating in this program.
9. I understand that the use of cameras, imaging, and digital devices is prohibited where privacy is expected, such as showers, locker rooms, restrooms and patient rooms.
10. I understand the use of a cell phone is prohibited.
11. I understand and agree that my obligation to keep this patient information confidential lasts forever.
12. I understand that there are legal penalties for violating the patient confidentiality laws and regulations.
13. I understand that failure to follow program rules may result in my dismissal from the program.

Department/Unit Identification:

School: _____

Student Name (Please Print): _____

Student Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____
(If student is a minor)

Approved: Nursing Recruitment/Marketing & Retention 1/21/14
Nursing Practice Executive Committee 1/21/14
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Revised: 3/10/14

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CERTIFICATE OF HEALTH & IMMUNIZATION REQUIREMENTS

(Please have this form signed by your physician or health care provider and return to Lisa Beckford.)

Check "1" Box To Indicate Which Experience You Are Applying For: ☐ Shadowing ☐ Internship ☐ Career Awareness Workshop

Student Name [Please Print]:_____

Student Signature: _____ Date:_____

School: _____ Grade Level:_____

I certify that _____ does not have any health problems that may pose a risk to hospital
[student's name]
patients or staff and to my knowledge is free from contagious or infectious disease and has no symptoms of illness.

1. **Rubeola (Measles)** If you were born *on or after January 1, 1957* check which of the following apply:
   - ☐ I have received 2 measles vaccines after January 1, 1968; **DOSE 1** [Date]:_____ **DOSE 2** [Date]: _____
   - ☐ I have had a titer drawn. **Date:**_____ **Result:** _____ **[Attach copy of result]**
   - ☐ If you were born ***before*** January 1, 1957, have you had the measles (rubeola)? ☐ Yes ☐ No
2. **Rubella (German Measles)** Check which of the following apply:
   - ☐ I have received the rubella vaccine after January 1, 1969. **Date:** _____
   - ☐ I have had a titer drawn. **Date:**_____ **Result:** _____ **[Attach copy of result]**
3. **Mumps** If you were born *on or after January 1, 1957* check which of the following apply:
   - ☐ I have received the mumps vaccine after January 1, 1968. **Date:** _____
   - ☐ I have had a titer drawn. **Date:**_____ **Result:** _____ **[Attach copy of result]**
   - ☐ If you were born ***before*** January 1, 1957 have you had the mumps? ☐ Yes ☐ No
4. **Tuberculin Skin Test** (Mantoux, ***NOT*** Tine)
   - ☐ **Date** of last skin test: _____ **Result:** ☐ Negative ☐ Positive
   - ☐ If positive, did you receive a chest x-ray? ☐ Yes ☐ No
     If *Yes* – **Date:**_____ **Result:** _____ **[Attach copy of result]**
5. **Chicken Pox**
   - ☐ I have had the chicken pox. ☐ Yes ☐ No If *Yes* – **Date:** _____
   - ☐ I had a titer drawn. ☐ Yes ☐ No If *Yes* – **Date:**_____ ☐ Negative ☐ Positive **[Attach copy of result]**
6. **Influenza vaccine (Annually)**
   - ☐ I have received the influenza vaccine. **Date:** _____
   - ☐ I have declined the influenza vaccine. **Signature:** _____ **Date:** _____

RECOMMENDED PROTECTIONS

7. **Hepatitis B Vaccinations**
   - ☐ I have received the hepatitis B vaccination series.
     DOSE 1 [Date]:_____ **DOSE 2** [Date]: _____ **DOSE 3** [Date]:_____
   - ☐ I have had the Hepatitis B surface antibody titer drawn. **Date:**_____ **Result:** _____ **[Attach copy of result]**
8. **Tetanus/Diphtheria or Tdap (please indicate)**
   - ☐ **Date of Last Booster:** _____ [Tetanus toxoid *only* is not sufficient.]

MD/Health Care Provider: _____ / _____ / _____
[Print Name] [Signature] [Date]

CERTIFICATE OF HEALTH & IMMUNIZATION REQUIREMENTS

Required if Student is a Minor:

Parent/Guardian Name: _____
[please print]

Parent/Guardian Signature: _____ Date: _____

OFFICE USE ONLY - Completed By Nursing Recruitment/Marketing and Retention:

This student's experience will take place with _____ in the

department/area of_____.

Approved: Nursing Recruitment/Marketing & Retention 1/21/14
Nursing Practice Executive Committee 1/21/14

Original Disseminated: 3/6/14

Reviewed:

Revised:

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