MetroHealth
Devoted to Hope, Health, and Humanity

The MetroHealth System

Student Application for Participation in Non-Funded Research Activity

Please Note: This application, including mentor/supervisor signature, must be completed and sent to the GME Office **at least two (2) weeks PRIOR** to the scheduled start date.

STUDENT – PLEASE PRINT LEGIBLY

Last Name_____ First Name_____ Middle _____

Date of Birth _____ SS #: xxx-xx-_____ Gender: ☐ MALE ☐ FEMALE

Address _____ Apt #_____ Phone # _____

City_____ State_____ Zip_____ E-mail _____

Emergency Contact (name & number)_____

Name of School_____ Degree program _____

Sponsoring Department _____ Mentor_____

Research Start Date _____ Research End Date _____

MetroHealth Approval

_____ _____

Mentor/Supervisor (Please Sign & Print name) Date

_____ _____

Graduate Medical Education Date

Student Submission Requirements

- ☐ Completed Application Form
- ☐ Confidentiality Acknowledgement Form, HIPAA Attestation and EPIC attestation
- ☐ Current TB test or CXR
- ☐ COVID Vaccination (Completed)
- ☐ Seasonal Flu Vaccine (if rotating between November 1 and April 30)
- ☐ Documentation of the following immunizations is PREFERRED, but not required. Students assume the risk of exposure to such diseases if immunizations are not secured and maintained over the course of their Program.
  - ➢ Hepatitis B (series of 3 immunizations or titers)
  - ➢ Measles, Mumps and Rubella (series of 2 immunizations or titers)
  - ➢ Varicella (Chicken Pox) (documented history, immunization or titer)
  - ➢ Diphtheria/tetanus (Record of booster within the past 10 years)

Departmental Checklist (Please check off completed items before sending to the GME Office.)

- ☐ Collect all required documents (application, confidentiality, HIPAA, EPIC, immunizations, TB test, flu shot)
- ☐ Send completed Application form, with ALL required documents to the GME office (visitingstudent@metrohealth.org)

ONCE APPROVED by GME:

- ☐ Submit Security Requests for access to the Network, EPIC, etc.
- ☐ E-mail IDCardAccess@metrohealth.org with student name, school, dates of research, phone number, last 4 of SSN and required swipe access

MetroHealth
Devoted to Hope, Health, and Humanity

Confidentiality Acknowledgment Form

I acknowledge my obligation to abide by The MetroHealth System's (MetroHealth) policies, to protect the privacy of MetroHealth's patients and employees, and to refrain from requesting, accessing, photocopying, faxing, discussing, or otherwise using or disclosing any "Confidential Information", including any "Protected Health Information" or other materials belonging to MetroHealth, and its employees and patients for any purpose other than the performance of my specified duties.

I understand that:

1. "Confidential Information" refers to all information and materials, irrespective of the media used, whether personal, financial, or medical in nature, which belongs to MetroHealth or has been entrusted to MetroHealth, its employees, and agents in the normal course of business operations. This provision incorporates all media including but not limited to, computer-based information, faxes, and electronic and paper copy medical records, etc.

2. "Protected Health Information" (PHI) is a subset of Confidential Information defined as individually identifiable health information which:
   a. Is created or received by MetroHealth, electronically or otherwise.
   b. Identifies the individual or could be used to reasonably infer the identity of the individual as it relates to the following:
      i. The past, present, or future physical or mental health condition of an individual,
      ii. The provision of health care to an individual, or
      iii. The past, present, or future payment for the provision of health care to an individual.

I agree that:

1. I will not access any medical record or other form of PHI in any electronic system or any paper medical record outside of normal business purposes.

2. I will not access my own medical record or other form of my own PHI or that of a family member without following proper procedures [i.e. by request, and accompanied with, the patient's signed authorization, to the medical record department].

3. I will take reasonable precautions to ensure that Confidential Information remains protected from loss, damage, or theft. This includes locking/ logging off of computer workstations when not actively in use as well as locking paper medical records and other confidential documents in file cabinets when not in use.

4. I will not create, generate, or maintain Confidential Information on my personal devices such as a home computer or non-MetroHealth laptop or handheld device.

5. I will not store electronic confidential information on any local hard drive (the "C" drive for example and I understand I need to contact information services if I am unclear where my local hard drive is) of any computer, laptop, or handheld or other portable electronic device, including but not limited to jump drives, CDs, and DVDs, unless I am authorized to do so by, or in consultation with MetroHealth's General Counsel

6. I will not remove any form of confidential information from the premises, including but not limited to hard copies of paper medical records, trade secret information, and other proprietary information, unless i am authorized to do so by,or in consultation with, MetroHealth's General Counsel.

7. I am aware that text messages are not encrypted. I will avoid sending any patient tracing information through the MetroHealth text paging system or through my personal sell phone.

8. I will not text or email pictures from my personal cell phone or handheld device.

9. Pictures cannot be sent through any system other than EPIC, unless the system is secure.

10. I will return any Confidential Information immediately upon the termination of my association with MetroHealth, whether permissibly in my possession or not (except for Benefit Plan and Compensation Information).

11. I understand that maintaining the confidentiality of sensitive material continues after my association with MetroHealth has ended and that disclosure of Confidential Information after my association ends may be grounds for legal action.

I have been fully informed and understand that any violation of MetroHealth's policies or my obligations as agreed to above, could result in the termination of my association with MetroHealth, in civil liability to MetroHealth its employees and patients, and/or in criminal charges. I understand that the duty of confidentiality of sensitive material continues after my association as a student to The MetroHealth System has ended and that disclosure of confidential information after my association as a student can provide grounds for legal action, including possible legal action by patients, families of patients, etc.

_____ _____

Student Name (Please PRINT neatly) **School**

_____ _____

Student Signature **Date**

MetroHealth
Devoted to Hope, Health, and Humanity

HIPAA Module & Attestation

All Trainees at MetroHealth are required to view a Guide to HIPAA video and Epic Training Video and complete two attestations prior to participating in any time on-site. There are also Epic Tip Sheets to review. The videos and tip sheets can be found at: https://gme.metrohealth.org/login?returnurl=/medical-student-information/login-for-online-resources.

The username is: Medstudents
The password is: access175

Please do not share this information.

Once you have watched the video, please complete the HIPAA Attestation below and the Epic Attestation on the next page.

HIPAA Attestation

I affirm that I have viewed the Medical Students' Guide to HIPAA video, in its entirety, as required by the Graduate Medical Education department at MetroHealth.

I attest that I understand and will comply with HIPAA's requirements.

_____
Print Name

_____ _____
Signature Date

MetroHealth

EPIC e-learning Attestation

I affirm that I have viewed all the required EPIC e-learning video modules and EPIC tip sheets, as required by the Graduate Medical Education department at MetroHealth.

The content of the EPIC videos and documents are for the sole purpose of training within the MetroHealth System. This content is the property of Epic Systems Corporation and subject to copyright law.

Print Name _____ School _____

Signature _____ Date _____