Dear Student,

Thank you for your interest in pursuing a student experience with us!

Our Student Experience Packet includes the following:

1. Student Application
2. Student Confidentially Statement
3. Release and Waiver of Liability
4. Student Expectations
5. Student Health Status

Please completely fill out and return the following forms **and a copy of your government-issued photo ID** to upahec@uglhealth.org and we will reach out to you within 3 business days.

Warm regards,

UP AHEC
The Professional Staff Office
Upper Great Lakes Family Health Center
P: (906) 372-3038
upahec@uglhealth.org

Student Expectations

For the duration of my student experience at
Upper Great Lakes Family Health Center,
I agree to:

Wear my student name badge.

Dress professionally with business professional attire in non-clinical settings and scrubs or business professional attire in clinical settings.

Not use personal devices in patient areas.

Not smoke within 250 feet of any clinic entrance.

Not use drugs or alcohol.

Notify the Professional Staff Office if a visitor from my School is coming to the clinic.

Be respectful and professional at all times.

Additionally, I understand that Upper Great Lakes Family Health Center reserves the right to end my student experience at any time if I do not abide by the rules set forth in this agreement and all other policies relative to my time in the clinic(s).

Student Name (print): _____

Student Signature: _____Date: _____

Parent Name (print): _____
(Required for students under the age of 18 only)

Parent Signature: _____Date: _____
(Required for students under the age of 18 only)

Release and Waiver of Liability

In consideration of an Internship or Externship at Upper Great Lakes Family Health Center:

I hereby acknowledge that there are dangers and risks of personal injury or illness inherent in observing the care and treatment of patients, in exposure to bodily fluids and other specimens, and otherwise. I knowingly assume the risk of the activity.

I hereby acknowledge that Upper Great Lakes Family Health Center is not responsible for any personal injury, illness, or other damages of any kind relating to my experience or exposure to patients, bodily fluids, or other specimens.

I hereby acknowledge that any bodily or personal injury, illness or other damage of any kind arising out of or related to the Internship or Externship will not be covered by workers compensation insurance or any other insurance coverage provided by Upper Great Lakes Family Health Center.

I hereby assume full responsibility for any risk of bodily or personal injury, or other damages of any kind arising out of or related in any way to the Internship or Externship at Upper Great Lakes Family Health Center, including any risks caused by the neglect of Upper Great Lakes Family Health Center.

I hereby release, waive, and forever discharged and covenants to hold harmless Upper Great Lakes Family Health Center its officer, directors, employees, insurers, and agents of and from all liability for any and all loss or damage, and any claim or demand on account of personal or bodily injury arising out of or related in any way to the Internship or Externship at Upper Great Lakes Family Health Center, including any and all loss or damage, claim or demand arising out of the neglect of Upper Great Lakes Family Health Center.

Student Name (print): _____

Student Signature: _____ Date: _____

Parent Name (print): _____
(Required for students under the age of 18 only)

Parent Signature: _____ Date: _____
(Required for students under the age of 18 only)

Witness Name (print): _____

Witness Signature: _____ Date: _____

Confidentiality Statement

As a student participating in an Internship or Externship at Upper Great Lakes Family Health Center, I understand that information about patients is confidential and may not be disclosed without the specific written consent of the patient. I further understand I will preserve the patient's rights to confidentiality by refusing to give out any patient information to any person. I agree to follow UGLFHC Policy 100-29 Confidentiality of Patient and Health System Information.

Today's Date: _____

Student Name (print): _____

Student Signature: _____

Parent Name (print): _____
(Required for students under the age of 18 only)

Parent Signature: _____
(Required for students under the age of 18 only)

Upper Great Lakes Family Health Center

Student Health Status Form

Part A: Immunization Status

Have you received the following vaccinations?

Measles/Mumps/Rubella	(MMR)	◯ Yes	◯ No	◯ Unsure	◯ *I have immunity due to prior disease presence*
Varicella	(Chickenpox)	◯ Yes	◯ No	◯ Unsure	◯ *I have immunity due to prior disease presence*
Meningococcal		◯ Yes	◯ No	◯ Unsure	◯ *I have immunity due to prior disease presence*
Tetanus/Diphtheria/Pertussis	(Tdap)	◯ Yes	◯ No	◯ Unsure	
Influenza in the last one year	(Flu)	◯ Yes	◯ No*	◯ Unsure*	
Hepatitis B	(Hep B)	◯ Yes	◯ No*	◯ Unsure*	

Part B: Communicable Disease

Have you ever had a positive Tuberculosis (TB) test? ◯ Yes* ◯ No ◯ Unsure

*If Yes, When?

Date of last chest x-ray? (mm/dd/yyyy) _____

Results? ◯ Normal ◯ Abnormal ◯ Unsure

Did you receive treatment with medication? ◯ Yes* ◯ No ◯ Unsure

*If Yes, Name of medication? _____

Duration? _____

Frequency? _____

Have you had a known exposure to a communicable disease (ie: COVID-19, Measles, Chickenpox, etc.) in the past 12 months?

◯ Yes If Yes, explain: _____

◯ No _____

Would you be like to be tested for COVID-19?

◯ Yes

◯ No

Have you had any severe bouts of unexplainable/undiagnosed f diarrhea, cough, fever, or skin eruptions in the past 3 months?

◯ Yes If Yes, explain: _____

◯ No _____

Have you traveled to outside of the United States in the past 12 months?

◯ Yes If Yes, name of the Country/ies: _____

◯ No _____

Upper Great Lakes Family Health Center

Student Health Status Form

I understand, as a student in healthcare, I am at risk for exposure to communicable diseases. I have been advised by UGLFHC that the above listed vaccinations are highly recommended to protect myself and others. I certify that the information above is complete and correct to the best of my knowledge and understand that intentionally providing false, misleading, or omitting information may be cause for disciplinary action, as defined by UGLFHC policy. I understand that I may be required to provide supporting records to support my answers above as a condition of employment, volunteer service, student experience, or other affiliation with UGLFHC. My signature below authorizes UGLFHC to obtain my records from the Michigan Childhood Immunization Registry (MCIR), if available, to support information I have listed above. I understand that if I decline, I may be asked to wear a mask to protect myself and others. I understand that UGLFHC reserves the right, as a condition of employment or other affiliation, to take additional actions to ensure our organization maintains a safe environment, as permitted or required by local, state, or federal law.

Student Name (print): _____

Student Signature: _____ Date: _____

Parent Name (print): _____

(Required for students under the age of 18 only)

Parent Signature: _____ Date: _____

(Required for students under the age of 18 only)

For Human Resource Department Use Only:

If the individual answered YES to any question in Parts B and C, forward to the Human Resources Department for approval.

HR Comments:

_____

_____

_____

Student Experience Program Application

Last Name/First name	Gender ☐Male ☐Female ☐Other	Birthdate (mm/dd/yyyy)

Address	City	State	Zip + 4	County

Primary Phone Number :	School Email Address:	Personal Email Address:

Ethnicity (select one)
☐ Hispanic
☐ Non-Hispanic

Race (select one)
☐ African American / Black
☐ American Indian / Alaskan Native
☐ Asian
☐ Native Hawaiian / Other Pacific Islander
☐ White
☐ More than one Race
☐ Prefer not to disclose

Veteran Status
☐ Active Duty Military: An individual serving in a full-time capacity in one (1) of the seven (7) uniformed services.
☐ Reservist: An individual serving in a part-time capacity in one (1) of the seven (7) uniformed services.
☐ Veteran (Prior service): An individual discharged from one (1) of the seven (7) uniformed services after serving a period of 90 days or more.
☐ Veteran (Retired): An individual discharged from one (1) of the seven (7) uniformed services after serving a period of 20 years or more OR An individual discharged from one (1) of the seven (7) uniformed services due to medical status.
☐ Individual is not a Veteran: A student who has never served in one (1) of the seven (7) uniformed services OR An student who was discharged from one (1) of the seven (7) uniformed services before serving a total of 90 days or more.
☐ Prefer not to disclose

Can you answer yes to any of the following? ☐ Yes ☐ No

- You are (or will be) the first generation in your family to attend college.
- You have or currently receive Scholarship or Loan for Disadvantaged Students.
- While growing up, you or your family ever used federal or state assistance programs (such as: free or reduced school lunch, subsidized housing, food stamps, Medicaid etc.).
- While growing up, you lived where there were few medical providers at a convenient distance.

In which kind of community did you grow up? (Select all that apply)
☐ Medically Underserved Area ☐ Rural (not a big city) ☐ Urban

In what school are you currently enrolled?	**Are you in the education program (Select one)** ☐ Part Time ☐ Full Time	**Anticipated Date of Graduation** (mm/dd/yyyy) / /
School Contact Name:	**School Contact Phone Number:**	**School Contact Email:**
In what Specialty would you like to have your student experience? ☐ Behavioral Health ☐ Dental ☐ OB/GYN ☐ Family Practice ☐ Sports Medicine ☐ Addiction Medicine ☐ Pediatrics	**Do you have a preceptor you would like to request?** ☐ No ☐ Yes, Name: _____ **How many hours would you like to complete?** _____ hours	**What is your preferred schedule for your student experience?** ☐ Monday Time: _____ ☐ Tuesday Time: _____ ☐ Wednesday Time: _____ ☐ Thursday Time: _____ ☐ Friday Time: _____
Rotation Start Date:	**Rotation End Date:**	*We will try to accommodate dependent upon preceptor availability.*

Information for this form is provided voluntarily. AHEC is required to report information about program participants. Data will be kept private to the extent allowed by law and will be referenced periodically to evaluate the effectiveness of AHEC services and programs.

vs. 05/2020

Student Experience Program Application

Educational Level You Are Currently In (Select one)

☐ Undergraduate-Year 1
☐ Undergraduate-Year 2
☐ Undergraduate-Year 3
☐ Undergraduate-Year 3

☐ Graduate-Year 1
☐ Graduate-Year 2
☐ Graduate-Year 3
☐ Graduate-Year 4
☐ Graduate-Year 5
☐ Graduate-Year 6
☐ Graduate-Year 7

☐ Residency-Year 1
☐ Residency-Year 2
☐ Residency-Year 3
☐ Residency-Year 4

☐ Fellowship-Year 1
☐ Fellowship-Year 2

Degree You Are Currently Working Toward (Select one)

☐ Student-Graduate Nursing
☐ Student-Nurse Midwife
☐ Student-NP-Acute Care Adult Gerontology
☐ Student-NP-Acute Care Pediatrics
☐ Student-NP-Adult
☐ Student-NP-Family
☐ Student-NP-Neonatal
☐ Student-NP-Pediatrics
☐ Student-Graduate-Nursing Doctorate
Specialty: _____
☐ Nursing-Licensed Practical/Vocational Nurse (LPN/LVN)
☐ Student-NP-Psychiatric/Mental Health
☐ Student-Alternative/Complementary Nursing
☐ Student-Nursing-BS/BSN
☐ Student-Certified Nursing Assistant
☐ Student-Registered Nurse (RN)
☐ Student-NP-Other advanced nurse specialist
☐ Undergraduate-Other
Specify:_____
☐ Other Graduate School
Specify:_____

In the future, I would like to work in a primary care setting (e.g. a clinic for Family Medicine, General Pediatrics).
☐ Yes ☐ No ☐ Not Applicable

In the future, I would like to enter a health career as a primary care clinician (e.g. Family Medicine, Pediatrics, General Dentistry, Nurse Practitioner, or Physician Assistant).
☐ Yes ☐ No ☐ Not Applicable

In the future, I would like to work with people who are medically underserved, that is people who face economic, cultural or linguistic barriers to healthcare.
☐ Yes ☐ No ☐ Not Applicable

In the future, I would like to work in rural areas, not big cities.
☐ Yes ☐ No ☐ Not Applicable

Have you been an employee at Upper Great Lakes Family Health Center in the past?
☐ No ☐ Yes

Have you been a student or volunteer at Upper Great Lakes Family Health Center in the past?
☐ No ☐ Yes

Have you ever been convicted or pled guilty to any crime (including but not limited to any traffic offense, petty offense, misdemeanor or felony)?
☐ Yes ☐ No

If yes, please provide details on a seperate sheet regarding date of conviction, offense for which you were convicted, the city, county and state in which you were convicted, and the sentence imposed on you. Disclosure of this information does not automatically exclude you from participation in the student experience program.

Are you currently under investigation or are there current charges against you for a felony?
☐ Yes ☐ No

If yes, please provide details on a seperate sheet regarding date of conviction, offense for which you were convicted, the city, county and state in which you were convicted, and the sentence imposed on you. Disclosure of this information does not automatically exclude you from participation in the student experience program.

Thank you for your time in completing this form and your student experience packet.

Please return to:
upahec@uglhealth.org

Information for this form is provided voluntarily. AHEC is required to report information about program participants. Data will be kept private to the extent allowed by law and will be referenced periodically to evaluate the effectiveness of AHEC services and programs.

vs. 05/2020