Nursing Fellowship Checklist

Facility and Program_____

Nurse Fellowship Program Participant's Name_____	Date Reviewed	Nurse Fellowship
1. I have read all the information presented in the Nurse Fellowship Program Participant Checklist and Orientation Manual, visited all the websites listed and understand all information provided.		
2. I have read and agree to adhere to the conditions of the Confidentiality Agreement and HIPPA Privacy, Security and Confidentiality Agreement provided in the Nurse Fellowship Program Participant Checklist and Orientation Manual.		
3. I have read the Conflict of Interest statement within this packet. I agree to safeguard the confidentiality of all information that I have access to in the course of my time at the Community Medical Center and to use proper procedures when required to release such information to others. I also agree to disclose to Community Medical Center any conflict of interest I may have. I understand that failure to do so may result in disciplinary action, up to and including termination of the clinical experience.		
4. I understand that in the event that I sustain an injury or have an accident during clinical experiences, I will receive emergency treatment if needed. I understand my health insurance will be billed for any necessary treatment and any balance will be billed to me. It is recommended that I carry personal health insurance. The responsibility for follow-up care remains with me.		
5. I reviewed the drug screen section of the Nurse Fellowship Program Participant Checklist and Orientation Manual. I am verifying that the information on my 10 panel drug screen is no more than **30 days** from the start of the facility year; I am verifying that the results show no discrepancies		
6. I have reviewed the Background Check section of the Nurse Fellowship Program Participant Checklist and Orientation Manual. I am verifying the records are clear with no hits. I understand that I must report to my facility and Community Medical Center designated contact, within 48 hours, any criminal charges, arrests or indictments that occur at any time during my rotations. I also understand that I must report any criminal charges, arrests or indictments that have occurred since the background check was provided, to the facility and COMMUNITY MEDICAL CENTER designated contact before I can begin my rotation. Failure to do so could lead to termination of the clinical experience.		
7. I acknowledge that I have received instruction on accessing the POLICIES & PROCEDURES for COMMUNITY MEDICAL CENTER. I agree that if there is any policy or provision in these documents that I do not understand, I will seek clarification from the Human Resources department and/or the nursing staff. In addition, I understand that these resources state COMMUNITY MEDICAL CENTER policies and practices in effect on the date of publication. I understand that nothing contained in these documents may be construed as creating a promise of a binding contract with COMMUNITY MEDICAL CENTER for any purpose. I also understand that these policies and procedures are continually evaluated and may be amended, modified, or terminated at any time. I expressly agree to be bound by the policies and guidelines outlined, as well as future modifications to such policies and guidelines.		
8. Proof of Current Immunizations: See Guidelines on page 8 of the Nurse Fellowship Program Participant Checklist and Orientation Manual. Immunization records are to be kept and maintained by the facility. Records are not to be submitted to COMMUNITY MEDICAL CENTER. By signing, I am verifying that the information on file with the facility is accurate and current. I also understand that I, as the Nurse Fellowship Program Participant, am responsible for keeping these records current.		

Nurse Fellowship Program Participant Signature_____ Date_____