

WESTERN CAROLINA UNIVERSITY
COLLEGE OF HEALTH & HUMAN SCIENCES
STUDENT AGREEMENT

I, _____, the undersigned student, enrolled in WCU's
(print name)

_____ program, hereby understand and agree to the following conditions during my clinical education at the assigned FACILITY(S):

I understand my participation in this program in which I will receive structured clinical experience is contingent upon my satisfactory performance and cooperation with the FACILITY staff, and if at any time I do not abide by the below conditions, I understand that I may be removed from the program.

I certify that I am covered by professional liability insurance and understand that I must provide proof of such coverage to the DEPARTMENT/PROGRAM .

I understand my clinical performance as it relates to program objectives will be evaluated on a regular basis by designated faculty and/or FACILITY representatives and that I may be dismissed if my performance is not satisfactory.

I understand that the records, documents, and all patient information of the FACILITY are legally confidential under a variety of laws including the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191. I will not divulge any personal and/or medical and/or business information concerning any person and/or record which I encounter at any FACILITY. If requested by the FACILITY, I agree to sign FACILITY'S Confidentiality Statement and Conflict of Interest Statement prior to my participation at the FACILITY.

I understand that I am responsible for my transportation to and from the FACILITY and on any reasonable special clinical assignment.

I have reviewed a copy of the Program Exposure Control Plan, which outlines the PROGRAM's requirements regarding vaccinations, precautions, and education concerning blood-borne pathogens, and my responsibilities and options should an exposure occur.

I am in compliance with North Carolina General Statute 130A-155.1 and North Carolina Immunization Rules and have provided the University with evidence of the following current immunizations: Diphtheria, Pertussis-Tetanus or Tetanus-Diphtheria; measles (rubeola), mumps; and rubella (MMR is the preferred vaccine); if required by the clinical FACILITY, a varicella zoster vaccine; and a tuberculin skin test (PPD) or a chest X-ray if skin test is positive.

I understand that I am responsible for following all behavioral standards and administrative policies and completing all requirements of the FACILITY, including satisfactorily completing and/or providing a record of immunization, health care (medical) insurance, health and/or other informational forms; criminal background check(s); and drug screening(s) as required by the FACILITY. I understand that I am responsible for any and all costs associated with the requirements of each FACILITY. Moreover I understand that if a FACILITY refuses me placement based on results of FACILITY required criminal background check(s) and/or drug screening(s) result(s), I may be removed from the PROGRAM.

I understand that I am responsible for adhering to the dress code of the FACILITY and for any necessary expense in attaining appropriate uniforms.

I understand that I am not an employee of the FACILITY.

I understand that I am responsible for reporting to the designated individual (faculty or FACILITY liaison) at the FACILITY on time during my scheduled assignment, and that I must notify the designated individual of any deviation from my scheduled arrival/departure times. I understand that the FACILITY and faculty liaison will, upon prior agreement, permit me Facility and University holidays where possible in meeting educational objectives.

I acknowledge that I understand the above conditions of acceptance and agree to perform accordingly.

Signature

Date