Attestation Form

School Affiliation: ____ CCPS Approval Date: ___________

Program: RN ____ BSN____ LPN____ CNA____ PT____ RT____ CRNA____ SURG. TECH____ Other ____

Program Director: __________________________________ Telephone: __________________________

Fax: ______________________ Email: _____________________________

Rotation Dates: Start: _________________ Finish: ___________________ Time: _________________

Course #:_____________________________

DAYS OF WEEK:

M _____ **T** _____ **W** _____ **T** _____ **F**_____ **S** ______ **Sun.** _______

Instructors Name: ____

Instructors Phone: ______________________________ E-Mail: ____________________

Instructor Completed Orientation Yes _____ No_____
(All Instructors Need To Complete Orientation)

Units Requested: _______________________________________

Number of Students: ___________

Name & Telephone # of Students: **(Required)**

____ ____

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Attestation Form

***All requirements MUST be met prior to the start of each rotation**

Physical Examination Completed	Yes ____	No _____
Criminal Back Ground Check Completed	Yes ____	No _____
Students met requirement for all required immunization	Yes ____	No _____
Current Influenza Vaccine	Yes ____	No _____
Signed Orientation completion on file	Yes ____	No _____
Code of Conduct Acknowledgement on file	Yes ____	No _____
Confidentiality & Security Agreement Form completed	Yes ____	No _____
HIPAA Privacy/Security Orientation Validation	Yes ____	No _____
PWH Hospital Online Orientation completed	Yes ____	No _____
Students have current CPR cards	Yes ____	No _____
Name and contact number of each student and instructor attached	Yes ____	No _____

As a designated representative of the school affiliation named above, I attest that the above information has been reviewed and approved, and is **maintained in each student/instructor's file at their facility**, and that each affiliation representative has been determined to be assigned appropriately for clinical rotation at Palms West Hospital. I agree that should any student/instructor fail to maintain the standards or fail to uphold the policies of Palms West Hospital, his/her immediate removal, and when necessary replacement, shall take place.

_____________________________________ _________________________

Program Director (Please Print) Date

____

Program Director (Signature)

____

School Affiliation

***Palms West Hospital will conduct annual audits for information listed above**
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Palms West Hospital – Education Department:

Received: Date and Time ____

Approved By: ____

1/2012