Huntsville Hospital
Corporate University

Phone 256-265-8025
Fax 256-265-9417
www.huntsvillehospital.org

Health System

Application for the

Medical Venturing Program





Medical Venturing Paperwork Required for Processing:

Completed Application, which includes the following forms:

__ Application/ Badge Form
__ Completed HIPAA Test
__ Affirmation Statement Form
__ Hold Harmless Form
__ Dress & Appearance Policy Form

Medical Test Required:

__ Current TB Skin Test (less than one year old)
Note: It takes 48 hours to complete this test, see page 2 of the application for more details

__ Photography Release Form

Dear Participant,

Thank you for sharing your interest in Huntsville Hospital's Medical Venturing Program through Corporate University. Medical Venturing provides students with opportunities to experience guest speakers, discussion groups, tours, and demonstrations from professionals serving in various healthcare fields. Huntsville Hospital's Post 630 is a partnership with Boy Scouts of America and membership includes both young men and women. Post 630 is the only Venturing Post in the region focusing on hospital-based healthcare. Participants do not to take part in hands-on patient care.

There are a few key facts about the Medical Venturing Program that you need to know:

1. **Eligibility**
   Participants must be, at a minimum, High School juniors or seniors in order to be eligible to participate. The minimum age to participate in the program is **15** years of age.

2. **Pre-requisites for Participation in the Program**
   Prior to beginning the Medical Venturing experience applicants must provide the following to Corporate University:
   - A completed **Medical Venturing Application.** The application form includes several sections that must be complete and signed. If a student has previously participated in Medical Venturing, a new application and dues payment is required each year.
   - **Boy Scouts of America Application**
   - A **HIPAA** (Health Insurance Portability and Accountability Act) **Test**
   - An **Affirmation Statement**
   - A **Hold Harmless Form**
   - A **Dress and Appearance Policy Form**
   - A **Current, Negative Tuberculin (TB) skin test** from your doctor or student health center is also required. The test should be **read within a year to be valid**. Please note, the TB Skin test process takes 48 hours between the TB injection and the reading by a physician. Include the certificate of results from your family physician or other primary care provider. For a $20 fee, the Occupational Health Group is another local resource for TB skin testing (located inside the Medical Mall at Governors Drive).
   - **Submit dues of $35** by cash or personal check made payable to: *Huntsville Hospital Corporate University*
   - **Photography Release Form**

3. **Meetings**
   - Youth participating in Medical Venturing meetings will have completed the Pre-requisites listed above.
   - Medical Venturers meet once per month, from September to May, from 6-7:30pm. Venturing resembles a "club" where members are not only learning about healthcare careers, they are cultivating a network of friends from other high schools and home schools.
   - Participants should plan to attend six (6) of the nine (9) meetings scheduled in order to receive a certificate of participation.
   - Meetings begin promptly at 6:00 p.m. Plan to arrive on time so speakers and/or tours will have sufficient time to cover all that is planned. Meetings end at 7:30p.m.
   - Two adult advisors will be present during each meeting, along with the scheduled speaker.
   - Parents/guardians providing transportation are asked to pick-up Venturers, from The Dowdle Center lobby, at 7:30 pm
   - Parking is located off Longwood Drive, behind the Governors Medical Tower-Spine & Neurosurgery Center.

Applicants need to submit their **completed Medical Venturing Application**, completed **Boy Scouts of American Application**, **current TB Skin Test,** and $35 dues to Corporate University's Medical Venturing Program contact, Rosita Karigan**.** Once we receive your completed paperwork you will be notified by email of your first meeting and topic. Packets can be dropped-off at the Dowdle Center, 109 Governor's Drive, faxed to (256) 265-9417, or mailed to our office at the following address:

Attention: Rosita Karigan
Huntsville Hospital's Corporate University
P.O. Box 1167; Huntsville, AL 35807

If you have any questions contact us by phone at (256)-265-8025 or email at rosita.karigan@hhsys.org. We look forward to helping you explore your career options in healthcare, and hope your experience will be rewarding.

Regards,

Rosita Karigan

Health System

Medical Venturing Application

Deliver to Corporate University located in the Dowdle Center at 109 Governors Drive or return by fax: (256) 265-9417

Office Use: Completed Requirements:
☐ Affirmation Statement ☐ TB Skin Test
☐ Application Form ☐ Boy Scout Application
☐ HIPAA Test ☐ Photo Release
☐ TB Skin Test Expires: ____/____/___
☐ Receipt Sent
☐ Entered in Spreadsheet
☐ Scanned _____

Name (Please print clearly):

(Minimum Age to participate is 15)

How Old Are You? **Birth date:** ____/____/____
Day Month Year

Name of High School (or Home School):

Check your class year ☐ **Sophomore** ☐ **Junior** ☐ **Senior** **Graduation Year:** 20____

Immunizations; in the last year I have:
☐ **Had a flu shot; Date ____/ _____/ ____**
☐ **Have not gotten a flu shot**

Home Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Preferred Phone#: (_____) _____

Email address: _____

If Applicant is under the age of 18,

Name of Parent/Guardian & Relationship:

_____

Cell Phone # of Parent/Guardian: _____

Parent/Guardian's email address: _____

Name the Health Care profession(s) you are interested in learning about during your Medical Venturing experience:

Choice 1.) **Choice 2.)** **Choice 3.)**

Medical Venturing meetings are held **Tuesday** nights, once a month, during the months of September through May. Youth are asked to attend six (6) meetings out of the nine (9) meetings scheduled.

2017 Meeting Dates:	2018 Meeting Dates:
☐ September 19 ☐ October 17 ☐ November 21 ☐ December 19 (Please check all the months available)	☐ January 16 ☐ February 20 ☐ March 20 ☐ April 17 ☐ May 15 (Please check all the months available)

Badge:

Students will be assigned a badge to wear during Medical Venturing meetings. The badge is only valid during meetings and should be turned in once the meeting has ended. ***Medical Venturers*** *will be escorted and wear their badge at all times on campus*

Parking:

If you are a participant on the Huntsville Hospital campus, the designated parking surface lot is west of the Governors Medical Tower, located off of Governor's Drive. If a participant fails to follow the parking guidelines, and does not park in the designated lot, fines are $50.00 for 1st offense and $250.00 for 2nd offense.

☐ I have read and understand the cover letter & application information.

Candidate Signature: ***Date Submitted:***

(Signature verifies that the participant has read the above statement & understands the guidelines for Medical Venturing Program.)

Health System

Youth Membership Form

This form is read by machine. Please print the numbers and letters as shown in the sample application.

YOUTH MEMBERSHIP

Unit type: (Fill in the circle.) ○ Cub Scout Pack ○ Boy Scout Troop ○ Varsity Scout Team ● Venturing Crew ○ Sea Scout Ship ○ Lone Cub Scout ○ Lone Boy Scout ○ Arrow of light earned

Unit Number: 630

For pack registration select one: ○ Tiger Club ○ Cub Scout ○ Webelos Scout

○ Mark here if new to Scouting. ○ Former Scout ○ Former Venturer ○ Former Sea Scout

If applicant has an unexpired membership certificate, registration may be accomplished in this unit by paying $1 for processing the transfer. Mark and attach certificate. It will be returned by the council.

○ Transfer application Transfer from council number: ___ Unit Type: ○ Pack ○ Troop ○ Team Crew Ship Unit Number: ____

Enter membership number from unexpired certificate: _____

Name and address information **(Please print one letter in each space.)**

First name **(No initials or nicknames)** | Middle Name | Last name | Suffix

Mailing Address | City | State | Zip code

Home Phone ___-___-____ | Date of birth (mm/dd/yyyy) __/__/____ | Grade

School

Ethnic background:
○ African American ○ Native American ○ Alaska Native ○ Asian
○ Caucasian/White ○ Hispanic/Latino ○ Pacific Islander ○ Other

Gender: ○ Male ○ Female ○ ***Boys' Life* Subscription**

Parent/guardian information ○ Mark here if address is the same as above. ○ I commit to be an active ScoutParent. ○ Mark here if you are the Tiger Cub adult partner.

○ Mark here if the adult partner/ScoutParent is not living at the same address; complete and attach an adult application.

Select relationship: ○ Parent ○ Guardian ○ Grandparent ○ Other (specify)

First name **(No initials or nicknames)** | Middle Name | Last name | Suffix

Mailing Address | City | State | Zip code

Home Phone ___-___-____ | Date of birth (mm/dd/yyyy) __/__/____ | Occupation | Employer | Gender: ○ M ○ F

Business Phone ___-___-____ | Ext. | Previous Scouting experience | Cell phone ___-___-____

Parent/guardian email address

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Signature of Parent/Guardian

Signature of unit leader (or designee)

Date __/__/____

Signature of Venturer

Registration fee $__.__ *Boys' Life* fee $__.__

HIPAA Fundamentals Training

Introduction
- At Huntsville Hospital, privacy of patient information has always been considered a basic right.
- What can happen when protected health information is inadvertently exposed? Personal harm to individuals, embarrassment, community mistrust, lawsuits, etc…

What is HIPAA
- HIPAA stands for **Health Insurance Portability and Accountability Act**. HIPAA is a relatively new federal law that protects Protected Health Information, or **PHI.**
- The law allows for penalties such as fines and/or prison for people caught violating patient privacy.
- HIPAA Privacy Regulations became **effective in April 2003** and the Security Regulation in April 2006.
- Part of our compliance with the HIPAA law is to provide the required awareness training for employees and workforce members.

Protected Health Information
- Protected Health Information (PHI) is **about patient information – whether it is spoken, written, or on the computer.** It includes health information about our patients. It can be information as simple as their name.
- Certainly we can share PHI when it is part of our job to do so, but beyond that you may have broken the law if you share patient information.

Need to Know
- A good way to determine if you should share patient data is to ask yourself… **"Do I or others need this information to do the job?"** Use this little test before you look at patient information or share it with others.
- Sometimes you may inadvertently hear or see information that you don't need to know. If so, just keep it to yourself.

Dispose of PHI Properly
- Trash and garbage bins are another place that might contain PHI. Be sure to dispose of patient lists and other documents that contain PHI in non-public areas.
- **If you see PHI in the trash in public areas, notify the supervisor immediately**.
- If you transport PHI, make sure it is secure when not in your sight, such as a locked vehicle.

The Privacy Officer
- **At HH we have a person responsible for insuring that privacy is maintained – The Privacy Officer.** However, no one person can know if we have a possible threat in every area of such a large organization.
- Each of us must do our part to protect patient information. **You should always report possible privacy problems to the manager in your area or to the Privacy Officer**.

Co-Workers, Friends, and Family
Situation: ***You hear about a friend that has had surgery, so you call a nurse on that floor to find out the details.***
- Friends and co-workers deserve the right to privacy just like any other patient. You cannot seek or share patient information for personal reasons. You may only obtain/share information that you need to know to do your job.
- You may personally ask the individual you know about their condition, and it is their choice what to share with you.
- You may also ask their permission to share their information with a common friend, but you should never do this without their permission.

"Don't be Curious"
Situation: ***You like to look at the patient directory or surgery schedule daily to see if you know anyone.***
- This is not within the scope of your job at this hospital.
- You are in violation of HIPAA laws and Huntsville Hospital policies.

Respect the Privacy of Patients
Situation: ***You are working in an area where caregivers are discussing health information with a patient, a family member, or another caregiver.***
- You can ask if you need to leave the area.
- You may quickly finish your task and leave.
- You must keep any health information you overhear to yourself.

Protect information in your Possession
Situation: ***In the process of doing your job, you use a list that contains patient names and possibly other patient information.***
- You should keep the information in your possession at all times.
- You should make sure that it is protected from others who would not need the information.
- You can turn it over so the information can't be viewed.
- You **should make sure when you are finished with the information that you have disposed of it properly**.
- Your supervisor may give you instructions for disposal of PHI.

HIPAA Fundamentals Test
This completes the fundamental overview of the HIPAA regulations. You now know and are responsible for what is required of you as an employee of Huntsville Hospital.
- HIPAA laws also require that we keep a record to show that you have been trained in patient privacy. You should now take the HIPAA FUNDAMENTALS TEST.

Medical Venturing Program – HIPAA Fundamentals Test

Name _____ **Date** _____

___1. HIPAA stands for:
- a. Health Information Protection Agency Association
- b. Human Instinct Protection Association Awareness
- c. Health Insurance Portability and Accountability Act

___ 2. PHI stands for:
- a. Patient Health Initiatives
- b. Personal Health Institute
- c. Protected Health Information

___ 3. The Privacy HIPAA law became effective:
- a. As soon as everyone in our hospital is trained
- b. April 2002
- c. April 2003
- d. December 2002

___ 4. Patient Information is protected when it is:
- a. Spoken
- b. Written
- c. On the computer
- d. All of the above

___ 5. If you are in a public area and you see PHI in the trash, you should:
- a. Report this to a supervisor
- b. Dispose of it properly
- c. Show it to a friend
- d. Both a. & b.

___ 6. The Privacy Officer is responsible for:
- a. Checking the trash
- b. Pulling medical records of patients
- c. Making sure Huntsville Hospital protects patient information

___ 7. You should ask yourself before you view or share patient information:
- a. Is this a personal friend or a relative not under my care?
- b. Will anyone see me reading this?
- c. Do I need this to do my job at Huntsville Hospital?

___ 8. Patient information that I use for my job:
- a. Isn't important to anyone else
- b. Should be protected until I have disposed of it properly
- c. Is the responsibility of my manager

___ 9. If I want to know about a friend that I see in the hospital, I should:
- a. Look at their medical record
- b. Ask the nurse
- c. Ask the individual

___ 10. If you see another person violating the HIPAA Privacy Laws or the HH Policies:
- a. You should ask them to stop
- b. Ignore it and mind your own business
- c. Report it to your manager or the privacy office (256-265-4477)

Health System

Medical Venturing Program –
Affirmation Statement on Security & Privacy of Information

HIPAA Fundamentals

HIPAA stands for Health Insurance Portability and Accountability Act. HIPAA is a federal law that was enacted in 2003, which protects Protected Health Information or PHI for patients. The law allows for penalties such as fines and/or prison for people caught violating patient privacy.

Protected Health Information, or PHI, is any patient information – whether it is spoken, written, or on the computer. PHI includes health information about patients in the hospital, and it can be as simple as their name. PHI cannot be shared outside of the hospital, even if you see the information in a public area like the trash. If witness PHI being shared, it needs to be reported to Huntsville Hospital's Privacy Officer at 256-255-9020.

Affirmation Statement

I, the undersigned, have read and understand the Huntsville Hospital policy on confidentiality of protected health information as described in the HIPAA Fundamentals Policy, which is in accordance with applicable state or federal law.

I also acknowledge that I am aware of and understand the policies of Huntsville Hospital regarding the security of protected health information including the policies relating to the use, collection, disclosure, storage and destruction of protected health information. This protection includes proprietary information.

In consideration of my employment or association with Huntsville Hospital, and as an integral part of the terms and conditions of my employment or association, I hereby agree, pledge and undertake that I will not at any time, during my employment or association with Huntsville Hospital, or after my employment or association ends, access or use protected health information, or reveal or disclose to any persons within or outside Huntsville Hospital, any protected health information except as may be required in the course of my duties and responsibilities and in accordance with applicable legislation and policies governing proper release of information.

I understand that user identification codes and passwords are not to be disclosed (or shared), nor should any attempt be made to learn or use another employee's code.

If I am an instructor, I understand that I assume responsibility for the actions of the students under my supervision to comply with the Security and Privacy of Information Policy.

If I am an employer, I understand that I assume responsibility for the actions of my employees to comply with the Security and Privacy of Information Policy.

Training: Members of the workforce receive required education concerning security and privacy during new Employee Orientation and during annual required training or upon commencement of the association. Any updates or changes to policies will be communicated via staff meetings, intranet and/or mandatory requirements tests.

Corporate Compliance: It is the responsibility of all employees and those associated with Huntsville Hospital to uphold all applicable laws and regulations. All employees must develop an awareness of the legal requirements and restrictions applicable to their respective positions and duties. The hospital has a corporate compliance program to further such awareness and to monitor and promote compliance with such laws and regulations. I am not aware of any violations of applicable laws or regulations and agree to report any violations to the Corporate Compliance Officer. Any questions about the legality or propriety of actions undertaken on or behalf of the Hospital should be referred immediately to the appropriate supervisory personnel, or to the Corporate Compliance Officer.

Excluded Party Status: I affirm that I am not an excluded party from participating in Federal health programs, nor am I under investigation which may lead to such sanctions.

Computer Applications: I further understand that I may be provided access to certain hardware and software applications, some of which may be proprietary to their respective vendors. I agree to keep the hardware and software applications confidential, to not disclose to third parties, and to use such hardware and software applications only for the benefit of Huntsville Hospital.

I understand that violation of this affirmation statement could result in me not being able to participate in Medical Venturing.

PRINT NAME: _____

School or Organization Name *(if applicable)*: _____

SIGNATURE: X_____DATE: _____

WITNESS SIGNATURE: X_____DATE:_____

04/2002, 12/2004, 1/2010

The Healthcare Authority of the City of Huntsville d/b/a Huntsville Hospital

WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT

1. In consideration for receiving permission to participate in Huntsville Hospital's Job Shadowing, Medical Venturing, or Internship or other Healthcare Observation Program (hereafter referred to as "the Program"), I hereby release, waive, discharge and covenant not to sue Huntsville Hospital, its officers, servants, agents and employees (hereinafter referred to as "releasees") from any and all liability, claims, demands, actions and causes of action whatsoever arising out of or relating to any loss, damage or injury, including death, that may be sustained by me, or to any property belonging to me, whether caused by the negligence of the releasees, or otherwise, while participating in the Program, or while in, on or upon the premises where the Program is being conducted, while in transit to or from the premises, or in any place or places connected with the Program.

2. I am fully aware of risks and hazards connected with being on the premises and participating in the Program, and I am fully aware that there may be risks and hazards unknown to me connected with being on the premises and participating in the Program, and I hereby elect to voluntarily participate in the Program, to enter upon the above named premises and engage in activities knowing that conditions may be hazardous, or may become hazardous or dangerous to me and my property. I voluntarily assume full responsibility for any risks of loss, property damage or personal injury, including death, that may be sustained by me, or any loss or damage to property owned by me, as a result of my being a participant in the Program, whether caused by the negligence of releasees or otherwise.

3. I further hereby agree to indemnify and save and hold harmless the releasees and each of them, from any loss, liability, damage or costs they may incur due to my participation in the Program, whether caused by the negligence of any or all of the releasees, or otherwise.

4. It is my express intent that this Release shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a Release, Waiver, Discharge and Covenant Not to Sue the above named releasees.

In signing this release, I acknowledge and represent that:

A. I have read the foregoing release, understand it, and sign it voluntarily as my own free act and deed;
B. No oral representation, statements or inducements, apart from the foregoing written agreement, have been made;
C. I, my parent or guardian is at least eighteen (18) years of age and fully competent;
D. I execute this Release for full, adequate and complete consideration fully intending to be bound by same.

In witness whereof, I have hereunto set my hand and seal this ___ day of _____, _____

Participant Signature: _____

Name Printed: _____

Parent or Guardian Signature (if participant is under 18 years of age): **_____**

Name Printed: _____

Witness:_____

Witness Name Printed: _____

Medical Venturing Program – Dress and Appearance Policy

Huntsville Hospital's Medical Venturing participants have a responsibility to adhere to the Hospital's dress policy. Therefore, your attire, grooming, and personal hygiene are critically important. We require that you observe the following specific standards regarding personal appearance and neatness while shadowing/observing in the hospital:

Clothing/ Attire

- **Shirts, Blouses, Dresses & Skirts –** Students should wear shirts, blouses or dresses with sleeves. Sleeves may be short (to the mid-bicep) or long sleeved. No sheer or sleeveless tops are permitted and no plunging necklines or cleavage should be showing. Lengths of dresses and skirts cannot be shorter than three inches above the knee. Dresses or skirts should not be clinging or tight.
- **Undergarments** – Lingerie, t-shirts or briefs should be covered by clothing.
- **Pants –** No shorts, blue jeans or work-out/sports clothing. Pants and tops should not reveal the midriff or back area.
- **Hair** is to be clean, well groomed, and a natural color (i.e. no pink, orange, blue). No distracting extremes in hair styling, dyeing, bleaching, or coloring is permitted. Shaving designs into the hair and Mohawks are not permitted. Hair and hair accessories must not be distracting or extreme. Hair below shoulder length should be confined if it falls forward over the face.
- **Hosiery –** Students should wear complementary socks or hosiery.
- **Shoes –** Clean, closed-toe shoes should be worn with the heel not exceeding 3" high.
- **Scrubs** – Some locations may require participants to wear scrubs. Participants will be informed if scrubs are required for their area.

Jewelry/ Adornment

- **Fingernails -** Students should not have artificial nails (which include acrylic/gel overlays, acrylic/gel nails, wraps, tips, and nail strengthener or hardener that is not removable by acetone. Fingernails should not exceed ¼ inch from the tip of their finger or have extreme nail art, or colors like black or orange.
- **Earrings** - No more than two earrings per earlobe are allowed. Earrings must not be larger than a quarter and are not permitted on the top of the ear or in the cartilage above the earlobe.
- **Rings -** No more than two rings per hand are allowed.
- **Bracelets and Necklaces** - Two necklaces and two bracelets are permitted.
- **Body Piercing** - Visible body piercing other than earrings is not permitted; this includes tongue piercing and forking, eyebrow piercing, and nose rings.
- **Tattoos** - Applicant should wear clothing that covers tattoos.

Hygiene

- Personal Hygiene is considered very important. Showering and the use of antiperspirant/ deodorant is required.
- Strong perfume or fragrances of any kind are not permitted. All fragrances are discouraged.
- Smoking is not permitted on the Hospital campus. Those using tobacco products must take measures to eliminate smoke odor from clothing, skin, and breath.

The Dress and Appearance Policy applies to Medical Venturing participants who are wearing a Hospital badge.

I have read and understand the Dress and Appearance policy. I understand that if I come to a Medical Venturing Program meeting in violation of this policy, I will not be allowed to remain for the program, and will not receive credit for attendance.

Print Name: _____Signature: _____Date: ____/____/_____

HUNTSVILLE HOSPITAL

CONSENT TO PHOTOGRAPH

Marketing & Public Relations

PHOTOGRAPHED EVENT:

Authorization for Filming or Recording Release Form

I authorize the release of the initialed item below to be disclosed in the manner described:

— I agree to grant an interview with, and/or to be photographed, videotaped, or recorded by a representative of print or broadcast media, and I understand that my information, image and/or voice may appear in print or broadcast media.

— I agree to grant an interview with, and/or to be photographed, videotaped, or recorded representative of Huntsville Hospital and I understand that my information, image and/or voice may appear in Huntsville Hospital promotional or educational material (advertisement, publication, video, web site, etc.).

— I agree to grant an interview and/or to be photographed, videotaped, recorded by a representative of law enforcement, public health or social service agency.

— I understand that I (will, will not) be identified by name and that protected health information (will, will not) be shared with the person performing filming or recording.

The purpose for the use/disclosure of this information is:

☐ Cooperation with request from media ☐ Education of health care professionals ☐ Hospital publicity or public education

☐ Investigation of a possible crime ☐ Other _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Huntsville Hospital Marketing Department. I understand that revocation will not apply to information that has already been released in response to this authorization.

I also understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

PRINT NAME	Day Time Phone Number
Signature (or Legal Representative) of individual being photographed, etc.	Legal Representative's Relationship to Patient
Physical Description Consenter	Witness
Date Department (if HH Employee)	Employee ID# (if HH Employee)

Identification of Personal Representative if the patient is unable to authorize:
__ Driver's License __ Work photo badge __ Other photo ID __ Power of attorney documentation

The original of this document is to be placed in the patient's medical chart and a copy to be maintained n Marketing & Public Relations (Fax 256-265-8921)

DATE:

Medical Venturing Program – Campus Map