ST. JOSEPH MERCY HOSPITAL
ANN ARBOR, MICHIGAN

APPLICATION FOR PHYSICIAN ASSISTANT/NURSE PRACTITIONER STUDENT ROTATION AND STUDENT PARTICIPATION AGREEMENT

Name: ____ Date: ____________
Last First Middle

Complete Mailing Address: ______________________________

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E-mail Address: ______________________________

Telephone: (   ) ______________________________ Social Security Number: ____________
Area Code Number

School: ______________________________
Name
____
Address
____

Student Health Services (i.e. person at your medical school to contact in the event of a medical emergency while at SJMH):

______________________________ (   ) ______________
Name Phone Number

Physician Assistant Student ______ Nurse Practitioner Student ______

Year in School at time of proposed rotation: 1____ 2____

Dates of proposed rotation: ______________________________

Department/Service Area of proposed rotation: ______________________________

Area of Interest: ______________________________

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In consideration of my proposed student clinical rotation at SJMH, I hereby agree to the following:

1. I will comply with all applicable standards of care, policies, procedures, rules and regulations of SJMH, and the instructions of SJMH supervisors, including, but not limited to those governing patient confidentiality.

2. I will submit to a TB skin test and/or chest x-ray provided by SJMH (or submit evidence of a recent negative test), and such other health-related testing and immunizations as may be required by SJMH or by the Michigan Dept. of Public Health or Occupational Safety and Health Administration. I understand that if I refuse any required immunizations or health-related testing, I may be terminated from the clinical rotation at SJMH.

3. I understand and acknowledge that SJMH has the right to take certain actions, if in its exclusive judgment I have failed to observe applicable policies, procedures, rules, regulations, or the instructions of SJMH supervisors, or have compromised the standard or quality of patient care or the safety of patients, or for other reasonable cause, including the failure to follow appropriate modes of dress, grooming and behavior. Said actions include but are not limited to my suspension or termination from the clinical rotation, limitations on my participation in the rotation, and unfavorable evaluations of my performance or character including the communication of such evaluations to the School and to other entities or individuals as required or permitted by law. **I hereby voluntarily release SJMH, Mercy Health Services, and their employees, agents and medical staff from any and all suits, claims, liability or demands based on such actions.**

4. I acknowledge that my clinical rotation shall be a part of my professional training, and not as an employee of SJMH. I understand that I shall not be entitled to compensation or employee benefits, nor shall I be considered an employee for purposes of unemployment compensation, minimum wage laws, Social Security or any other purpose.

5. I have read this Participation Agreement carefully, and have had sufficient opportunity to ask questions and have it explained to me before signing it.

Please send completed application to:
Diane Jones, Ph.D., PA-C
Email: Diane.Jones@stjoeshealth.org

____________________ ______________________________
Date Participant's Signature