



Re: Application for Individualized Learning Experience

Dear Applicant:

Attached you will find an application which must be completed and returned along with the following documents in order for you to be allowed special consideration for a learning experience at St. John's Health System.

- *Consumer Report Disclosure & Release* (enclosed)
- Copy of Drivers' License or Student I. D. Card (must have a photo)
- *Health Record Affirmation* (enclosed) with attachments
- Application fee of \$50.00

There is an additional document, *Consent to Urine Testing*, which should be brought with you when you come to St. John's Employee Health Department for testing.

Please review, complete and attest to the application in its entirety. It is not necessary to procure a sponsor prior to submitting the application unless the sponsor is to be a physician. If the sponsor is to be a physician, their signature must be obtained prior to submitting the application.

When completed, please return the *Application for Learning Experience* and *Health Record Affirmation* (with attachments) and the *Consumer Report Disclosure & Release* to the address below. The application fee of \$50.00 must accompany the application for planning of your requested experience to proceed. The approval process will take approximately two-three weeks and you will be notified by phone of the outcome of your request. Please do not attempt any activities related to your request until you have received notification of approval.

St. John's is dedicated to offering quality learning experiences and makes every effort to provide these opportunities, while ensuring the safety of and maintaining the highest quality of care for its patients. If you have any questions, please contact the Education & Organizational Development Department at 417-820-3005.

Address for return of documents: St. John's Hospital  
Attention: Executive Director, EOD Department  
1235 East Cherokee  
Springfield, MO 65804

Sincerely,

A handwritten signature in blue ink that reads "Vickie Donnell".

Vickie Donnell MS, MEd, RN  
Executive Director, Education & Organizational Development Department

**ST. JOHN'S**  
Education and  
Organizational Development



## Application for Individualized Learning

Complete this application in full. Submit the completed, signed form and required attachments to Education & Organizational Development Department (address information in cover letter). You will be notified of approval. Do not attempt any type of experience at St. John's until notified of approval. Submission of this application does not guarantee participation in a learning experience.

Please include the following with this completed application:

- *Consumer Report Disclosure & Release*
- Copy of Drivers' License or Student I. D. Card (must have a photo)
- *Health Record Affirmation* (enclosed) with attachments
- Application fee of \$50.00

### PERSONAL INFORMATION

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Residence Address \_\_\_\_\_

Phone (of preferred contact) \_\_\_\_\_ E-mail Address \_\_\_\_\_

Male       Female      Date of Birth \_\_\_\_\_

### EDUCATION/TRAINING

(List school/college/university currently attending)

Institution Name \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_

Year (check one)       Freshman       Sophomore       Junior       Senior       Graduate Level

Major/Area of Interest: \_\_\_\_\_

Future Career Plans: \_\_\_\_\_

### EMPLOYMENT

(List current employment if healthcare related)

Institution Name \_\_\_\_\_

Address/City/State/Zip \_\_\_\_\_

Dates employed From: \_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_

### STATEMENT OF PURPOSE FOR LEARNING EXPERIENCE (include experience requested and reason for request)

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## Health Record Affirmation

To provide an environment that is safe for St. John's co-workers, as well as the health and safety of patients and visitors the following requirements must be met prior to participating in learning experiences at St. John's.

- \_\_\_\_\_ Documentation of positive MMR Titer or evidence of MMR immunization (please attach).
- \_\_\_\_\_ Documentation of a negative TB skin test (Mantoux method) performed within the past 12 months or negative chest x-ray within previous 12 months (please attach).
- \_\_\_\_\_ Written statement [may use back of this form for statement] of having had Varicella (chicken pox), evidence of Varicella immunization or documentation of positive Varicella titer (please attach).
- \_\_\_\_\_ Documentation of positive Hepatitis B titer, evidence of Hepatitis B immunization series or signed declination (please attach).
- \_\_\_\_\_ Documentation of positive Hepatitis A titer or evidence of Hepatitis A immunization, if experience includes contact with dietary, childcare, or exposure to sewage (attach if appropriate).
- \_\_\_\_\_ Documentation of seasonal and any other mandated flu vaccine(s) required during flu season (September thru February)

~Subject to revision as a result of recommendations by the Centers for Disease Control and Prevention or St. John's Health System policy~

A six panel drug screen and criminal background check will be required.

You are hereby informed that participation in patient care in the St. John's Health System may expose you to patients with contagious disease. In signing this document you accept this risk and release St. John's Health System from any liability should you contract an illness from such exposure.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature (required if less than 18 years of age) \_\_\_\_\_

## Bring this document with you



### Consent to Urine Testing

I (print name), \_\_\_\_\_ hereby authorize St. John's Health System of Springfield, Missouri and its certified contractors to test my urine for the presence of drugs.

I authorize disclosure of the results of such test to the Vice President of Human Resources, or designee, at St. John's Health System, 1235 East Cherokee, Springfield, Missouri.

I understand that this testing is not part of any medical treatment, testing for illness, or therapy rendered to me, but is testing for the presence of illegal drugs only. I understand that I will be asked to list any prescribed medications I am taking and the name of the doctor who prescribed them.

I understand all offers for educational experiences are made as conditional offers. The conditions include review of criminal histories of applicants, testing for illegal drugs, and other considerations.

I agree to hold harmless and release from all liability both St. John's and its certified contractors from and against any claims, actions, or losses of any kind that arise out of or in connection with the testing or the disclosure of the test results.

I have carefully read and understand the conditions and statements presented above.

I AGREE TO PURSUE A LEARNING EXPERIENCE WITH ST. JOHN'S UNDER THE CONDITIONS PRESENTED ABOVE.

Signature \_\_\_\_\_ Date\_\_\_\_\_

Employee Health hours of operation 7:00 a.m. – 4:30 p.m. Monday through Friday. Closed for lunch from 11:30 a.m. – 12:00 p.m.

Enter from the main entrance. Go straight until you pass the gift shop, then turn left at the intersection. Continue down the hall past the cafeteria to the 2<sup>nd</sup> office door on the right.

## CONSUMER REPORT DISCLOSURE & RELEASE

### DISCLOSURE

In connection with your employment or application for employment (including contract for services), consumer reports may be requested from USIS Commercial Services ("USIS"). These reports may include the following types of information: names and dates of previous employers, reason for termination of employment, work experience, accidents, academic history, professional credentials, drugs/alcohol use, information relating to your character, general reputation, personal characteristics, mode of living, educational background, or any other information about you which may reflect upon your potential for employment gathered from any individual, organization, entity, agency, or other source which may have knowledge concerning any such items of information. Such reports may contain public record information concerning your driving record, workers' compensation claims, credit, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records; as well as information from USIS concerning previous driving record requests made by others from such state agencies and state provided driving records.

You have the right to make a request to USIS, upon proper identification, to request the nature and substance of all information in its files on you at the time of your request, including the sources of information and the recipients of any reports on you that USIS has previously furnished within the two-year period preceding your request. USIS may be contacted by mail at P. O. Box 33181, Tulsa, Oklahoma, 74153, or by phone at (800) 381-0645.

### RELEASE

**I AUTHORIZE, WITHOUT RESERVATION, USIS, AND ANY PARTY OR AGENCY CONTACTED BY USIS, TO FURNISH THE ABOVE-MENTIONED INFORMATION.**

USIS is authorized to disclose all information obtained to the requesting entity for the purpose of making a determination as to my eligibility for employment, promotion or any other lawful purpose. I agree that such information which USIS has or obtains, and my employment history if I am hired, may be supplied by USIS to other companies that subscribe to USIS. If hired or contracted, this authorization shall remain on file and shall serve as ongoing authorization for the procurement of consumer reports at any time during my employment or contract period.

By signing below, I certify that I have read and fully understand this release, that prior to signing I was given an opportunity to ask questions and to have those questions answered to my satisfaction, and that I executed this release voluntarily and with the knowledge that the information being released could affect my being hired, my employment, or my eligibility for promotion.

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Print Applicants First Name: \_\_\_\_\_

Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Have you used another last name while employed? If so, please list:  
\_\_\_\_\_

Applicants Signature: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Drivers License #: \_\_\_\_\_ State Issued: \_\_\_\_\_



































## **OBSERVER IN SURGERY ORIENTATION**

- 1) **EAT LITE BREAKFAST WITH PROTEIN.**
- 2) **WEAR COMFORTABLE SHOES.**
- 3) **LEAVE VALUABLES IN CAR.**
- 4) **REPORT TO SURGERY FRONT DESK AFTER CHANGING INTO SCRUBS.**
- 5) **WEAR SOMETHING TO HOLD HAIR UP AND NO DANGLY EARRINGS, NECKLACES AND NO MORE THAN ONE BAND/ RING ON EACH HAND. ONLY WATCH ON WRIST. SHORT SLEEVE T-SHIRT OK. **NO LONG SLEEVES OR TURTLE NECK T-SHIRT!****
- 6) **HATS AND SHOE COVERS ARE LOCATED AT DESIGNATED AREAS BEFORE ENTERING SEMI- RESTRICTED AREAS. **BE SURE TO WEAR YOUR NAME BADGE.****
- 7) **BEFORE ENTERING THE OPERATING ROOM, PUT ON MASK, EYEWEAR AND PERFORM HAND HYGIENE.**
- 8) **FOLLOW THE INSTRUCTIONS OF THE CIRCULATING NURSE.**
  - \*STAY 12 – 18 INCHES AWAY FROM ALL STERILE SURFACES.**
  - \*WHEN PASSING A STERILE FIELD/ SURFACE OR SCRUBBED PERSON, ALWAYS KEEP YOUR FRONT FACING THE STERILE FIELD AND/ OR SCRUBBED PERSON.**
  - \*NEVER GO BETWEEN TWO STERILE FIELDS.**
- 9) **IF YOU FEEL DIZZY AND/OR HOT, LET CIRCULATING NURSE KNOW. IF YOU ARE ABLE, BACK UP AND LEAN AGAINST THE WALL. SLIDE DOWN THE WALL AS YOU SIT ON THE FLOOR. **(BEWARE, SITTING STOOLS HAVE WHEELS!)****
- 10) **DON'T FORGET ABOUT HAND HYGIENE!**

**HAVE A GREAT LEARNING EXPERIENCE!**





## **St. John's Surgery Observer Form**

I, \_\_\_\_\_, have completed the orientation required to observe surgery at St. John's Hospital. I understand the information that was provided and will comply with those standards and recommendations.

Signature & Date \_\_\_\_\_

Instructor signature \_\_\_\_\_