Mercy-Springfield Medical Explorers

SPRING 2019

All information submitted with this application is confidential. **PRINT** only.

Welcome to the Mercy Medical Explorers Program! Please complete the attached application form and bring it with you to the orientation date listed below. You will need to have <u>all</u> the items completed before the orientation session. The table listed below is a guide for you to use in order to make sure you have all the mandatory requirements. Thank you so much!

ORIENTATION DATE **Thursday – January 29, 2019**
5 P.M – 7:30 P.M. (Please eat before attending)
Mercy Hospital - Springfield CAMPUS
Catherine McAuley Conference Center

APPLICATION FORM CHECK LIST

COMPLETED & BROUGHT TO ORIENTATION	EXPLORER	PARENT	Healthcare professional	COMPLETED (✓ or Ø)
1. BSA LEARNING FOR LIFE FORM –COMPLETED AND SIGN	X	X		
2. APPLICATION FORM	X	X		
3. APPLICATION ESSAY	X			
4. RELEASE OF RESPONSIBILITY FORM-SIGNED		X		
5. 2 LETTERS OF REFERENCE (individually placed in sealed envelopes)	X			
6. HEALTH RECORD AFFIRMATION		X	X	
7. VARICELLA (CHICKEN POX) VERIFICATION		X	X	
8. PROOF OF SCRUBS PURCHASE – TEAL GREEN	X			
9. **$35 dues (**Credit Card online or CASH/CHECK at orientation…exact change only**)**	X			
COMPLETED DURING ORIENTATION JANUARY 29, 2019				
1. DUES RECEIPT	X		X	
2. ORIENTATION ATTENDANCE-DOCUMENTATION	X		X	
3. CONFIDENTIALITY AGREEMENT-DOCUMENTATION	X		X	
COMPLETED BY JANUARY 29, 2019				
4. T-Spot for Tb testing (at Mercy Out-Patient Lab)	X			
5. VERFICATION OF ALL LAB TESTING COMPLETED	X			
6. INFLUENZA VACCINATION-COMPLETED (not required for Spring Session)				
7. MERCY NAME BADGE FOR SPRING 2019	ONLY IF <u>ALL</u> ITEMS ABOVE ARE COMPLETED			

(X's indicate responsible party)

VERSION: 9/6/18

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EXPLORER NAME (please print) _____

☐New Explorer	☐Renewing Explorer - INITIAL Date joined (Month/ Year)_____

Personal Information		
Name:	**Birth Date**:	
Address:	**City/ State:**	**ZIP:**
Cell Phone:	**Emergency Contact Phone:**	
email address:		
Parent/guardian Names:		

Employment Information		
Relative employed at Mercy?	**Job Title:**	**Department:**

Education Information	
School:	**Grade:**
Honors/Organizations/School Activities :	
Volunteer activities:	
Special interest in healthcare:	
Would you like to be a Mercy-Springfield Medical Explorer Executive Committee member?	

References
Attached are two reference letters to be completed by a teacher and/or one other person outside of your school (clergy, group leader, coach, etc.)

Applicant's Statement
I hereby state that all of the information that I provide on this application is true and accurate. I understand that if I am accepted and any such information is later found to be false in any respect, I may be dismissed from the Mercy-Springfield Medical Explorer Program.
Signature **Date**

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Essay (typed or printed)

Please write a brief (200 words) essay on your interest in a healthcare field and why you would like to be considered for the Mercy-Springfield Medical Explorer Program.

Include answers to the following questions:

Why are you interested in a healthcare career?

What are your area(s) of interest in healthcare?

Why do you want to be considered for the Mercy-Springfield Medical Explorers Program?

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Release of Responsibility

The Mercy-Springfield Medical Explorers program is a voluntary program designed to introduce participants to a variety of medical situations. Participants are responsible for their own well-being, including hydration, eating of meals, wearing appropriate clothing, and acting in a reasonable and appropriate manner. Participants are financially responsible for any injury or harm to the explorer resulting from their own actions which caused or contributed to the injury or harm.

Mercy-Springfield Hospital is not responsible for accidents which occur due to a participant's own actions and will not be held financially liable for these situations. The undersigned hereby holds harmless Mercy-Springfield Hospital, its agents, employees, successors, heirs, executors, administrators and all parent and subsidiary corporations from all claims and demands of any nature, causes of action, and any liability resulting from personal injury and consequences thereof, while participating in the Medical Explorers program with Mercy-Springfield Hospital.

Mercy- Springfield is not held financially liable for required seasonal vaccinations or additional lab testing if requested by Mercy Coworker Health Services.

Medical Explorer: _____

(Please print)

Signature: _____ Date _____

Parent / Guardian Signature:

_____ Date _____

(Required if you are considered a dependent and / or covered by insurance through parent/guardian.)

Parent / Guardian Contact Phone (required) _____ __

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Health Record Affirmation

To provide and environment that is safe for Mercy co-workers as volunteers, as well as the health and safety of patients and visitors, the following requirements must be met prior to participating in learning experiences at Mercy-Springfield for the Mercy Medical Explorers. Please fill in the blanks and mark the appropriate box.

Varicella (chicken pox):

- ☐ Statement: _____ (name of explorer) had the chicken pox in _____ (year).

OR

- ☐ Varicella immunization: Documentation that _____(name of explorer) had a Varicella immunization or a positive Varicella titer in _____ (year).

TB BLOOD test (Tspot method) Mercy will provide this service at no charge.

- ☐ Documentation of negative Tb test performed within the past 12 months

OR

- ☐ Negative chest x-ray within previous 12 months provided from physician.

Seasonal Influenza vaccine performed after **AUGUST 2018**
(Required for Medical Explorers rotating during Flu Season (September- April).

- ☐ Documentation that the explorer received a seasonal flu shot.
- ☐ The explorer and/or parent/guardian accepts full financial responsibility for this service at a facility of their choice.

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

Medical Explorer: _____

Printed Name: _____

Signature: _____ Date _____

Parent / Guardian Signature: _____ Date _____
(Required if you are considered a dependent and / or covered by insurance through parent/guardian.)

~ Subject to revision as a result of recommendations by the Centers for Disease Control and Prevention ~

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Health Record Affirmation

EMPLOYEE HEALTH REQUISITION

DATE: _____

Name: _____

Medical Explorer SS # (required): _____

DOB (required): _____ **M** ____ **F**____

NO CHARGE: Send results to Coworker Health Services

- ☐ **Co-worker**
- ☐ **Post Offer**
- ☐ **Auxiliary**
- ☐ **Jr. Auxiliary**
- ☐ **Hospice**
- ■ **Medical Explorer**
- ☐ **Allied Health**
- ☐ **Student**
- ☐ **Intern**

RUBELLA

HBSAB

VARICELLA ZOSTER

MUMPS

_____

Parent or Guardian Signature (required) *Date*

(Required if you are considered a dependent and / or covered by insurance through parent/guardian.)

This test will only be completed at no charge ONLY if requested by Coworker Health Services.

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Mercy Medical Explorer Clinical Pathway Survey

The clinical rotations areas of the hospital are divided into 4 groups - following the clinical paths that patients may take while they are at Mercy-Springfield. Explorers sign up for the 2-hour clinical rotations within these areas over the 4 month session. The goal is to document attendance to at least 10 clinical rotations within a session. You can only attend one clinical pathway area per session, but you can sign up for at least 3 different sessions per year. Please indicate your preference below by ranking your first choice #1, second choice ` #2 etc…

Name	phone #	email

Please rank in order of your preference the clinical pathway you would like to be a candidate. Each Pathway will extend over 14 weeks, with variable attendance dates that you choose. Every attempt will be made to accommodate your preference to your #1 and #2 choices.

	Surgical Track	**Includes Surgical Intensive Care, Respiratory Therapy, Radiology, Surgical Nursing,**
	Medical Track	**Includes Medical Intensive Care, Labor and Delivery, Radiology, Respiratory Therapy, Medical Nursing, Lab**
	Cardiac Track	**Includes Burn Unit, Cardiac Nursing, Oncology, Phlebotomy, Radiology, Respiratory, Lab**
	Neurological Track	**Includes Emergency Department, Neuro Intensive Care, Neuro Nursing, EMS Dispatch, Phlebotomy**

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Letter of Reference

To Whom It May Concern:

_____ is applying for membership into the Mercy Springfield Medical Explorers Program. Medical Explorers is a program that provides high school students interested in the healthcare field the opportunity to interact and learn from other healthcare professionals. You have been selected by the student to provide a reference. Please provide the following information :

Name: _____ Contact phone number: _____

Occupation : _____

Relationship to student: _____

How long have you known this student? _____

Please rate on a scale from 1 (lowest) to 5 (highest) the following areas:

Responsibility & Maturity	1	2	3	4	5
Eagerness to Learn	1	2	3	4	5
Effective Listening Skills	1	2	3	4	5
Interest in Healthcare	1	2	3	4	5

Why would you recommend this student for the Mercy Medical Explorer program?
(Please attach separate sheet if necessary)

Reference Signature: _____ Date: _____

Thank you for completing this reference. Please place in an envelope, seal and write your signature across the seal. Return the reference back to the student for hand delivery on the designated orientation date. Thank you

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