Mercy Medical Explorers – Mercy Springfield

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 registered online and have paid your dues before the orientation session to obtain the TB test form (lab draw) that will cover the expense of TB testing if used. All outstanding items will need to be submitted February 11th, 2020, prior to the monthly business meeting. The table listed below is a guide for you to use to make sure you have all the mandatory requirements. Thank you so much!

ORIENTATION DATE **Tuesday – January 28, 2020**
5 P.M – 7:00 P.M. (Please eat before attending)
Mercy Hospital - Springfield CAMPUS
Catherine McAuley Conference Center

APPLICATION FORM CHECK LIST

Printed / Completed before Orientation	EXPLORER	PARENT	Healthcare professional	COMPLETED (✓ or Ø)
1. Verification of Online Registration and Payment	X			
2. Career Exploring Youth Application	X	X		
3. Mercy Medical Explorer Application Form	X	X		
a. Career Exploration Essay	X			
b. Release of Responsibility	X	X		
c. 2 Letters of Reference (in sealed envelopes)	X			
d. Clinical Pathway Survey	X			
e. Student/Shadow Vaccination Verification Form			X	
4. Proof of Scrubs	X			
Completed / Distributed during Orientation January 28th				
1. Orientation Attendance Documentation	X			
2. Confidentiality Agreement-Documentation	X			
3. T-Spot form for Tb testing			X	
Completed & Submitted February 11th				
4. Pink copy of Completed T-Spot from Mercy Out-Patient Lab	X			
5. Flu Vaccine (2019-2020 season)			X	
6. Personal File reconciled				
7. Receipt of MERCY NAME BADGE (Spring 2020)	All items must be completed before a name badge can be issued.			

(X's indicate responsible party)

Mercy Medical Explorers – Mercy Springfield

EXPLORER NAME (please print)

____

<table>
<tr><td colspan="3">☐New Explorer</td><td colspan="3">☐Renewing Explorer - INITIAL Date joined (Month/ Year)_________</td></tr>
<tr><th colspan="6">Personal Information</th></tr>
<tr><td colspan="4">Name:</td><td colspan="2">Birth Date:</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">City/ State:</td><td colspan="2">ZIP:</td></tr>
<tr><td colspan="3">Cell Phone:</td><td colspan="3">Emergency Contact Phone:</td></tr>
<tr><td colspan="6">email address:</td></tr>
<tr><td colspan="6">Parent/guardian Names:</td></tr>
<tr><td colspan="2">Relative employed at Mercy?</td><td colspan="2">Job Title:</td><td colspan="2">Department:</td></tr>
<tr><th colspan="6">Education Information</th></tr>
<tr><td colspan="5">School:</td><td>Grade:</td></tr>
<tr><td colspan="6">Honors/Organizations/School Activities:</td></tr>
<tr><td colspan="6">Volunteer activities:</td></tr>
<tr><td colspan="6">Special interest in healthcare:</td></tr>
<tr><td colspan="6">Would you like to be a Mercy-Springfield Medical Explorer Executive Committee member?</td></tr>
<tr><th colspan="6">References</th></tr>
<tr><td colspan="6">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.)</td></tr>
<tr><th colspan="6">Applicant's Statement</th></tr>
<tr><td colspan="6">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.</td></tr>
<tr><td colspan="4">Signature</td><td colspan="2">Date</td></tr>
</table>

Mercy Medical Explorers – Mercy Springfield

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 is your area(s) of interest in healthcare?

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

Mercy Medical Explorers – Mercy Springfield

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) _____________________ __

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**
	Cardiac Track	**Includes Burn Unit, Cardiac Nursing, Oncology, Phlebotomy, Radiology, Respiratory**
	Neurological Track	**Includes Emergency Department, Neuro Intensive Care, Neuro Nursing, EMS Dispatch, Phlebotomy**

Mercy Medical Explorers – Mercy Springfield

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

ALL REFERENCES ARE KEPT CONFIDENTIAL.

Mercy Medical Explorers – Mercy Springfield

Letter of Reference

To Whom It May Concern:

______________________________________ is applying for membership into the Mercy-Springfield Medical Explorer s 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

ALL REFERENCES ARE KEPT CONFIDENTIAL.

Mercy Medical Explorers – Mercy Springfield

Mercy Health System Student/Shadow Vaccination Verification Form

Legal Name (Print): ___________________________________Date of Birth: ________________________

The *required* immunizations MUST BE documented on this form. Signature is required by your School Nurse, Personal Physician, Nurse Practitioner or Physician Assistant to attest to accuracy.

TUBERCULOSIS SCREENING (Required)			
Two 2-step TB skin test within the last 12 months. These are two TB skin tests placed at least 1 week apart but **within 1 year**		*First Skin Test (Required)*	*Second skin test (required at least 1 week after the first test)*
	Date Placed:		
	Date Read:		
OR	Induration (mm):		
	Result (Pos/Neg):		
A 1 step TB test **within the last 12 months** (IGRA) (Provided by Mercy Springfield) (T-Spot, Quantiferon Gold, etc.)	Date:		Result:
Chest x-ray - in the last two years **with** documentation of official report (for positive results only)	Date:		

REQUIRED IMMUNIZATIONS									
	Vaccinations				Titer(s)				
Tdap (One vaccine within the last 10 years)	Date:								
MMR Two MMR vaccinations at least 1 month apart given after age 1 ---OR--- Born prior to 1957 (exempt) ---OR--- Positive titers to Measles, Mumps, and Rubella ---OR--- Documentation of 2 Measles, 2 Mumps, and 1 Rubella vaccination	*(#1)*	AND	*(#2)*	**OR**	Titer positive date: **Measles**	AND	Titer positive date: **Mumps**	AND	Titer positive date: **Rubella**
Varicella (chicken pox) - Series of two doses or immunity by positive blood titer	*(#1)*	AND	*(#2)*	**OR**	Titer positive date:				
Flu Vaccine (if at Mercy between October 1 - March 31) Date subject to change per CDC	Date:								
Hepatitis A (required only for students and shadowers in Daycare or Nutrition/Food Service)	N/A	**OR**	*(#1)*	AND	*(#2)*	**OR**	Hep A Titer Date:		

RECOMMENDED IMMUNIZATIONS				
Hepatitis B Vaccine	Vaccinations			Titer
	mo/day/year	mo/day/year	mo/day/year	Titer date/result
(Hepatitis B vaccine is a 3-vaccine series that is completed at intervals recommended by the CDC. If a negative HBsAB is found after a completed first series, a second series may be indicated. If a second negative HBsAB is resulted after a completed second series, diagnosis of non-responder.)	*1st Series*			
	(#1)	*(#2)*	*(#3)*	*Date:* *Result:*
	2nd Series (if given)			
	(#1)	*(#2)*	*(#3)*	*Date:* *Result:*

Information MUST be verified and signed by the Explorer applicant's School Nurse, personal Physician, Nurse Practitioner, or Physician Assistant. **Signature attests to accurate immunization documentation.**

____/_______________

Signature (of School Nurse/Physician/Nurse Practitioner/Physician Assistant) with **Credentials** **Date:**

____/_______________

Printed name and location of provider (of School Nurse/Physician/Nurse Practitioner/Physician Assistant) **Office Phone #:**

Spring 2020