Cook County Health

New Students
Required Documents

(Non-Affiliated Schools)

COOK COUNTY
HEALTH

COOK COUNTY
HEALTH

Leadership

Toni Preckwinkle
President
Cook County Board of Commissioners

Israel Rocha, Jr.
Chief Executive Officer
Cook County Health

Board of Directors

M. Hill Hammock
Chair of the Board

David Ernesto Munar
Vice Chair of the Board

Robert Currie
Hon. Dr. Dennis Deer, LCPC, CCFC
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Raul Garza
Ada Mary Gugenheim

Joseph M. Harrington
Mike Koetting
Heather M. Prendergast, MD, MS, MPH
Robert G. Reiter, Jr.
Otis L. Story, Sr.

Department of Professional Education
1950 W. Polk 5th floor, Suite 5210 Chicago IL 60612
(312) 864-0394

M4 Clerkship Checklist

Before Rotation Begins....

- [ ] Contact clinical department for availability
- [ ] Complete the application for JHS rotations and the Health Professions Student Individual Agreement for Limited Clinical Training Form- submit directly to clinical department

Please obtain and complete the following requirements prior to your rotation.

You will need to email your documentation to the department contact once you've obtained their approval.

- [ ] Valid School ID or letter of good standing
- [ ] Cook County Health (CCH) Summary of Requirements Certificate of Compliance Health Form
- [ ] Printed screen shots of educational modules (hand washing, infection control and student orientation module) with passing score 150/150= 100% https://cookcountyhealth.org/education-research/
- [ ] Criminal background check (must be completed within 1 year of your start date)
- [ ] Proof of HIPAA training (link to module if you do not have current training https://www.proprofs.com/quiz-school/story.php?title=NTgwOTI2
- [ ] Proof of professional liability insurance (1million occurrence per 3 million aggregate)
- [ ] Proof of drug screen within 30 days before rotation start date (5 panel)
- [ ] COVID Attestation Form
- [ ] Confidentiality Acknowledgment Form *
- [ ] HIPAA/Fire/Safety Acknowledgment and Agreement Form

Revised 04/2022

John H. Stroger, Jr. Hospital of Cook County

Fourth Year Medical Student Elective Clerkship Application

{PLEASE PRINT}

Name in Full: ______________________________
(Last) (First) (Middle)

Date of Graduation: ______________________________

E-Mail address: ______________________________

Permanent Address: ______________________________

Telephone: ____________________ Sex: ________

Medical School: ______________________________

Medical School Registrar's Office Phone Number: ______________________________

Please indicate ONE choice only. You must apply separately for each program

REQUESTED DATES: ____________________ **TO** ____________________

YOU MUST CONTACT THE RELEVANT DEPARTMENT TO DETERMINE DATE AVAILABILITY BEFORE COMPLETING THIS APPLICATION.

Anesthesiology ____
Neurology ____
Toxicology ____
Medicine
- Cardiology ____
- Dermatology ____
- Endocrinology _____
- Gastroenterology ____
- Hematology ____
- Infectious Disease ____
- Intensive Care ____
- IM Sub-I ____
- Nephrology ____
- Short Stay Unit ____
- Oncology ____
- Primary Care ____
- Pulmonary _____

Burn ____
Radiology ____
Trauma ___
Surgery
- Thoracic ____
- General Surgery ____
- Neurosurgery ____
- Oncology ____
- Oral Surgery ____
- Orthopedics ____
- Otolaryngology ____
- Colon and Rectal ____
- Plastic Surgery ____
- Urology ____
- SICU ______
- Ophthalmology ____

Emergency Medicine ____
Psychiatry ____
Physical Medicine & Rehabilitation ____
Family Medicine _____

JOHN H. STROGER, JR. HOSPITAL APPROVAL

____
Program Chairperson **Date**

OR

____
Department Head (Print and Sign)

MEDICAL SCHOOL APPROVAL

The applicant is a current medical student in good standing. I certify that the information recorded herein is true and correct to the official records of this situation.

____
Signature of School Official **Date**

____
Title **Date**

AFFIX SCHOOL SEAL OR STAMP HERE

DENIAL

____
Denied/ Signature (Print and Sign) Date:

School Official: Return this application to the Department of Professional Education

____
Student's Signature **Date**

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HEALTH PROFESSIONS STUDENT
INDIVIDUAL AGREEMENT FOR LIMITED CLINICAL TRAINING

I________________________("Student"), hereby represent that, in consideration of being granted permission to observe and, if authorized by the applicable Hospital Supervisor, to participate in supervised patient care at Stroger Hospital of Cook County ("Hospital"), located at 1901 West Harrison Street, Chicago, Illinois, hereby agree to the following terms and provide the following information, understanding that the County and its Hospital are relying upon such information and upon such agreement:

1. ***Date of Birth and Residence.*** My date of birth and current residence are as follows:

   ____

2. ***School/Program Affiliation.*** I am a current student in good standing at the following school and am enrolled in an accredited educational program in a health profession as follows:

   ________________________ at ________________________________

   Health Care Discipline *College Name and Address*

3. ***Assignment.*** I request permission to observe the provision of health care to patients at Hospital in the

   ________________ department on______________________(dates) and to participate in supervised patient care activities upon being expressly instructed to do soby my Hospital supervisor.

4. ***Student Supervision***. I understand that I have status of trainee and may render patient care or other services only under direct supervision and as directed by my Hospital supervisor, an individual who shall be designated by the head of the department listed in paragraph (3) above. I agree to abide by all Hospital policies and procedures while onsite at the Hospital. I understand and agree that the Hospital retains full authority and responsibility for patient care at the Hospital and that either the department head or my Hospital supervisor may at any time terminate my participation in Hospital activities.

5. ***Identification.*** While on the Hospital premises, I shall at all times exhibit an appropriate identification badge furnished by the Hospital, which I shall return to the Hospital at the conclusion of the assignment. I shall identify myself to Hospital patients and staff in accordance with Hospital procedures.

6. ***Health Requirements:*** I have provided the following documentation to the Hospital's Department of Professional Education Office prior to my participation in activities atHospital:

1) Proof that I received the Hepatitis B Vaccination and other vaccinations that maybe required by the Hospital;

2) Proof of Tuberculosis (TB) screening within one year of my participation inactivities at Hospital.

Further, I represent that I am in a condition of health which enables me to participate safely in patient care activities at the Hospital, subject to the following limitations:

____.

7. ***Emergency Medical Care.*** I give my permission for the Hospital to provide emergency medical care and treatment in the event of injury and illness occurring at the Hospital. I understand that I am responsible for the expense associated with such treatment.

8. ***Confidentiality.*** I acknowledge that all Hospital patient information is absolutely confidential and shall not disclose directly, indirectly, or by implication, or use such information in any way at any time, except solely as required to perform assigned tasks at the Hospital.

9. ***Professional Liability Insurance.*** If requested by the Hospital, I have provided the Department of Professional Education with proof that I am covered by insurance which insures against professional liability I may incur while participating in patient care activities at the Hospital.

10. ***Volunteer Status.*** I understand that I will be paid no compensation by the County with respect to my activities at the Hospital and that I am neither an employee of the County nor am I entitled to any benefit to which County employees may be entitled such as, but not limited to, compensation, retirement or disability benefits, workers' compensation benefits or any other benefits.

11. ***Governing Law.*** This Agreement shall be interpreted under and governed by the laws of the State of Illinois. Venue shall lie in a court of competent jurisdiction located within the County of Cook, Illinois.

Signed by Student:

____________________________ ________________

Printed Name Date

Acceptance by Hospital:

____________________________ ________________

Department of Professional Education Date

Acceptance by Clinical Supervisor at Hospital:

____________________________ ________________

Department Chair or Program Director

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COOK COUNTY HEALTH (CCH) SUMMARY OF REQUIREMENTS CERTIFICATE OF COMPLIANCE HEALTH FORM-PROFESSIONAL EDUCATION

Last Name **First Name** **DOB**

Program/School **Start Date**

Below you will find the CCH health requirements. All students must meet the requirements listed before starting a rotation at Stroger. Annual updates are required.

- **Tuberculosis Screening**- Initially you will need to provide the results of a *Interferon Gamma Release Assay (*often the Quantiferon- Gold is used) done within the last 3 months, and annually complete the *Tuberculosis Surveillance Questionnaire* (below).
- **Vaccinations:**
  - **Measles** - Documentation of 2 MMRs vaccines* or titers demonstrating immunity to measles
  - **Rubella** - Documentation of 1 MMR vaccine* or titers demonstrating immunity to rubella
  - **Mumps** - Documentation of 2 MMR vaccines* or titers (immunity is not mandated)
  - **Varicella** - Documentation of 2 Varicella vaccines* or titers (immunity is not mandated)
  - **Hepatitis B** – Documentation of series of 3 vaccines*, include Hepatitis B surface antibody titer if available (required if vaccination done outside the U.S.)
  - **Influenza** -Documentation of vaccination required for personnel here Oct. –March
  - **COVID Vaccine-** (Complete COVID vaccination required within 2 weeks of your start date).

*Applies to vaccines administered in the U.S.

****

(For CCH Staff only)

☐ TB Screening	☐ Measles	☐ Hepatitis B	☐ Influenza
☐ Rubella	☐ Mumps	☐ Varicella	☐ COVID

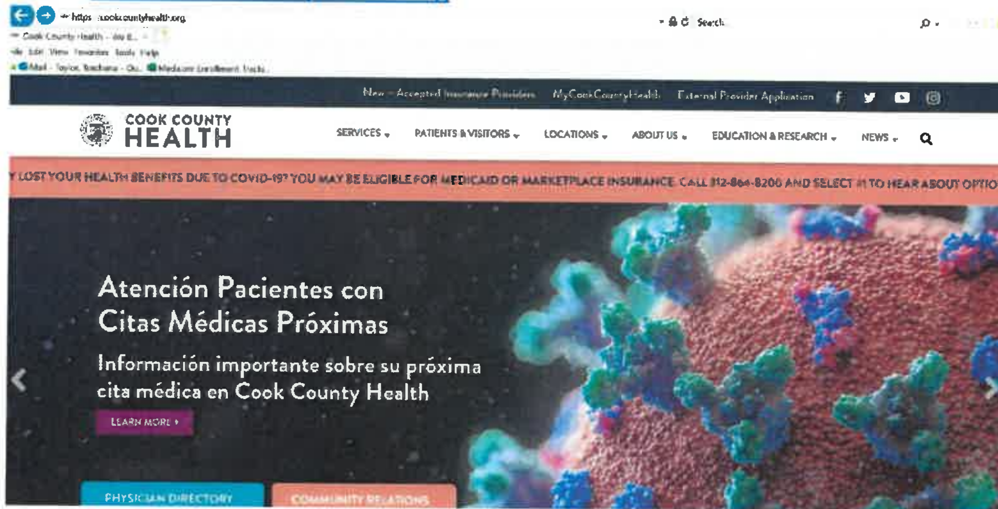
12/2021

COOK COUNTY
HEALTH

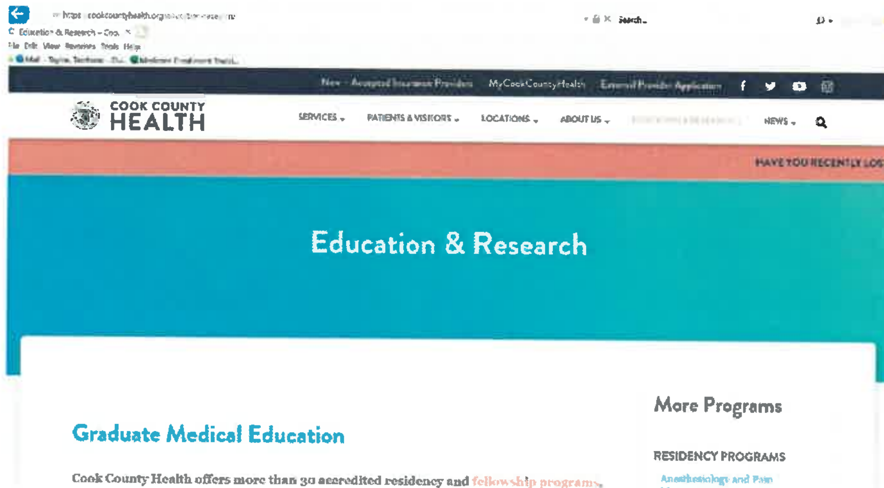
Educational Modules

Greetings from Cook County Health Department of Professional Education. Below you will find instructions on how to complete the required annual training modules.

1. Go to www.cookcountyhealth.org



2. Click on Education & Research



3. Scroll down to Education Modules and complete the 3 modules that are listed:

    - Hand Hygiene
    - Infection Control
    - Student Orientation.

- Current Research Projects
- Office of Research & Regulatory Affairs (IRB)
- Research Onboarding
- Collaborative Research Unit

Education Modules

In order to participate in rotations at John H. Stroger, Jr. Hospital, you must be familiar with some very important issues that may differ slightly from your home institution. The link below will bring you to educational modules on Infection Control, Handwashing and a brief orientation to the hospital that includes topics such as Patient Identifiers, Fire Safety and Pain Control for Patients. Completion of these modules is required prior to beginning a rotation at Stroger.

Click & review each of the appropriate modules below:

- Hand Hygiene Education
- Infection Control Module
- Resident and Student Orientation Module

Please Note:

-**Student Orientation Module:** Please complete the quiz and provide your test results as proof of completion. A passing score 150/150= 100%.
https://cookcountyhealth.org/education-research/

Hand Hygiene: Please complete the training module and take a screenshot of the final slide as proof of completion.

-**Infection Control Module:** Please complete the training module. At the end, you will receive a confirmation email. The confirmation email will be requested as proof of completion.

If you have any questions or experience technical issues, please contact:

Rita Coleman rcoleman@cookcountyhhs.org &

Taschana Taylor taschanataylor@cookcountyhhs.org for assistance.

Thank you,

Name check
We provide IL STATE NAME CHECK background check $25

Please open below link - READ IN DETAIL EACH LINE and follow the instructions

STEP # 1.. .... ✓

Please open the below link, please fill out both pages and email back to us.

Page 1. Name check / CBC Request form
Page 2. Credit Card Payment Form
Please email back to us, total cost is $25 for IL STATE NAME CHECK /CBC Background.

http://www.fingerprintingchicago.com/Name-Check-UCIA-Request.pdf

OR
Step 2............
Please open the below link and then please click on Tab "**Name Check UCIA IL State Only" and follow the instructions.**

http://www.fingerprintingchicago.com/name-check-ucia.html

A Fingerprinting U S Photo, Inc.
210 S Clark St
THE CLARK ADAMS BLDG
Ground Floor Lobby
Chicago, IL 60603

Ph: 312-782-8143 / 312-782-8144
Email: fingerprintingchicago@gmail.com
www.fingerprintingchicago.com

NAME CHECK / CBC REQUEST FORM

UCIA - IL STATE ONLY

Person Being Checked: **Name Checks cost $25 each person, each time.**

Last Name: ______________ First Name: ______________ Middle Initial: ______

Daytime Phone: ______________________________

E-Mail: ______________________________

Date of Birth: ______________________________

Sex: Male Female

Race: White Black Hispanic Asian Other

E-Mail: ______________________________

Send Results to: (For your protection, results will only be sent via e-mail.)

Name: ______________________________

E-Mail:
(You may list multiple e-mails to receive the results.)
____
____

Phone: ______________________________

Payment: **Please see attached Credit Card Payment Form.**
Or e-mail the payment information directly to fingerprintingchicago@gmail.com

A Fingerprinting U S Photo, Inc.
210 S Clark St
THE CLARK ADAMS BLDG
Ground Floor Lobby
Chicago, IL 60603

Ph: 312-782-8143 / 312-782-8144
Email: fingerprintingchicago@gmail.com
www.fingerprintingchicago.com

CREDIT CARD PAYMENT FORM

Name Checks cost $25 each person, each time.

Name(s) Being Checked: ______________________________

Card-Holder Name: ______________________________

Company Name: ______________________________
(if applicable)

Billing Address: ______________________________

City, State, Zip: ______________________________

Country: ______________________________

Phone: ______________________________

E-Mail: ______________________________

Credit Card Type: Visa Mastercard Discover American Express
(circle only one)

Credit Card Number: ______________________________

Expiration Date: ______________ 3- or 4-Digit Code: ______________

Total Amount to be Charged to the Card ($25 per person) ______________________________

Card Holder Signature: ______________________________

I understand and agree to the cardholder agreement & by doing so, I give my permission to A Fingerprinting U S Photo to charge the above card for the amount listed.

** You may also e-mail the above information directly to us: fingerprintingchicago@gmail.com **

HIPAA And Corporate Compliance For Stroger Students

After completing an on-line module, trainees must pass this quiz with a score of 10/10 =100%.

https://www.proprofs.com/quiz-school/story.php?title=NTgwOTI2

COVID Attestation

COOK COUNTY HEALTH

Rotator Name: ____________________

Institution: ____________________

Rotation: ____________________

Date: ____________________

I agree to produce proof of appropriate COVID vaccination before the start of my rotation and to complete an online symptom checker daily. In addition, I will adhere to all of the critical CCH protections such as 4 per elevator car, mask wearing (even in the non-patient care areas), protective eye wear when seeing patients and appropriate social distancing with the understanding there will be "zero tolerance". I understand that if I am not compliant with these safeguards, I may be dismissed from the rotation.

COVID Behavior	Rotator Initials	Coordinator Initials	CCH Staff Initials
Must wear a mask and practice social distancing at all times			
Must wear eye protection (and a mask) when seeing pts. whose COVID status is unknown			
Must observe the CCH 4-person limit on the elevators			
Must complete a symptom checker **daily**			
Must produce proof of appropriate COVID vaccination			

Together We Are Stronger...

We must take care of our patients and each other as that is how we can get to the other side of the pandemic. Please support each other and let the CCH Professional Education office know if there is anything you need. Stay safe!

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CONFIDENTIALITY ACKNOWLEDGEMENT

The Cook County Health and Hospitals System, doing business as Cook County Health (CCH) has an ethical and legal responsibility to protect the privacy of its patients and to maintain the confidentiality of protected health information (PHI). CCH workforce members, including but not limited to employees, volunteers, interns, residents, and vendors, must make every effort to prevent unauthorized use or disclosure of medical, personal, financial, and other data pertaining to patients, employees, and hospital operations. Therefore, it is imperative that each individual with access to any such information be familiar with and adhere to the CCH HIPAA: Privacy Management policy, No. CC.012.01, and all other applicable CCH and departmental policies and procedures relating to the privacy, security and confidentiality of CCH and patient data. Under no circumstances shall any person access, release or disclose PHI, employee information, or information that is proprietary to CCH to anyone unless it falls within the performance of one's legitimate CCH duties. To ensure that all individuals with access to such information acknowledge their responsibility to protect the privacy and confidentiality of said information, please read the following statements and sign your acknowledgement below:

1. I acknowledge that all medical, financial, and personal information is confidential and protected against unauthorized viewing, discussion, and disclosure.
2. I further understand that all such information is privileged and confidential regardless of its format: electronic, written, overheard, or observed.
3. I agree to use the CCH computer-based information systems for the sole purpose of performing my legitimate job duties.
4. I agree NOT to use the CCH computer-based information systems to access information on myself, my family, or any other person outside the performance of my job duties.
5. I agree to follow all established policies and procedures in relation to changing, deleting, and destroying information in any form.
6. I understand that the passwords assigned to me to access CCH computer-based information systems are confidential and may not be shared with anyone under any circumstance, nor will I allow any other individual to document under my login or password.
7. I understand that any actions I take in the CCH computer-based information systems are tagged with my unique identifier as established in my user profile, and such actions can be traced back to me. I further understand that I am solely responsible for all activity logged under my username.
8. I acknowledge that my signature on this Confidentiality Agreement signifies I have read, understand, and am committed to its principles.
9. I understand that this signed and dated document will become a part of my permanent personnel record.

I understand that I may view, use, disclose, or copy information only as it relates to the performance of my duties. Any unauthorized viewing, discussion, or disclosure of this information is a violation of CCH policy and may be a violation of state and federal law. Any such violation may lead to my immediate termination and possible civil liability and/or criminal charges.

____

Print Name **Department/Title**

____

Signature **Date**

____

Witness by – Signature Date **Date**

PLEASE SELECT YOUR HOME LOCATION

☐ ACHN ☐ CERMAK ☐ CORE ☐ OAK FOREST ☐ PROVIDENT ☐ STROGER

COOK COUNTY HEALTH
1950 West Polk, Chicago IL 60612
www.cookcountyhhs.org
(312) 864-6000

HIPAA/FIRE/SAFETY ACKNOWLEDGEMENT AND AGREEMENT FORM

AGREEMENT FOR ______________________________
(ROTATION/CLINICAL PROGRAM)

I, ______________________________
(FIRST NAME / LAST NAME

A, ______________ STUDENT AT ______________
(TYPE OF STUDENT) (INSTITUTION)

Upon approval by the department, I hereby agree to accept the position of student at a Cook County Health location for the period starting ______________ And ending ______________.

I hereby agree to return by ID Badge to the Department of Professional Education and, if relevant, library books, at the end of my rotation. I further agree to abide by the rules and regulations of Cook County Health while here on my rotation.

I affirm that I have received basic HIPAA training at my home institution. ________ Initial Here

I affirm that I have received basic fire safety training at my home institution. ________ Initial Here

I affirm that I reviewed, and agree to abide by the HIPAA and fire safety materials provided to me by the Department of Medical Administration. ________ Initial Here

If I have a blood-borne pathogens exposure, I agree that it is my responsibility to report it to my clinical supervisor, and immediately report to Stroger's employee Health Service *(EHS 3rd Floor, Administration Building, 7:30 am – 4:00 pm)* or if after hours, to the Emergency Room. If EHS is closed at the time of exposure, I agree to report to EHS the following business today. ________ Initial Here

Signature: ______________________ Date: ______________

Current Address: ______________________________

Current Phone Number: ______________________________