

**Berkeley Medical Center (BMC) & Jefferson Medical Center (JMC)**

The purpose of this form is to ensure that articles set forth in Academic Affiliation (AA) are completed and comply with regulatory bodies. (The Joint Commission, Corporate Compliance and HIPAA). **Students may not begin rotations/observations until all paperwork is received by the Education Department.** *Please submit a new form for each location and department/unit (unless capstone).* **Send signed form to:** allison.flynn@wvumedicine.org.

<b>Name of School:</b> _____	<b>Indicate BMC or JMC:</b> _____
<b>Name of Program:</b> _____	<b>Department/Unit:</b> _____
<b>Semester &amp; Year:</b> _____	<b>Start &amp; End Date:</b> _____
<b>Requester Name:</b> _____	<b>Days of Week (if same):</b> _____
<b>Requester Email:</b> _____	<b>Shift/Time Frame:</b> _____
<b>Requester Phone:</b> _____	

Please list instructors & groups assigned below: <i>ex: Ann Wu (Grp 1 &amp; 2)</i>		
1.	2.	3.
4.	5.	6.

Please list students (group #) & dates on unit: <i>ex: Ro Smith (Grp 1), 9/1 &amp; 9/8</i>		
1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.
13.	14.	15.
16.	17.	18.
19.	20.	21.
22.	23.	24.
25.	26.	27.
28.	29.	30.

**Please initial each if you have verified the requirement is met for all listed above (must be done prior to start)**

- \_\_\_\_\_ Student/instructor provided with Student Affiliation Code of Conduct – available on website: <https://wvumedicine.org/berkeley/programs/students/> (applies to both BMC & JMC)
- \_\_\_\_\_ Documentation of proper immunizations per CDC recommendations for healthcare workers r/t: MMR, Hep B, Varicella, Tdap
- \_\_\_\_\_ Documentation of influenza vaccine during flu season (required annually)
- \_\_\_\_\_ Documentation of current PPD or Chest X-ray with negative result (within previous 12 months)
- \_\_\_\_\_ Criminal Background Check
- \_\_\_\_\_ WV CARES Fingerprinting (Beh. Health rotations Instructors only)
- \_\_\_\_\_ Urine Drug Screen with negative result
- \_\_\_\_\_ Student/Instructor are NOT on the excluded List of Excluded Individuals/Entities (LEIE)
- \_\_\_\_\_ Liability insurance coverage by school/and or student
- \_\_\_\_\_ School provided instruction in Standard Precautions/Blood Borne Pathogens PRIOR to first clinical day.
- \_\_\_\_\_ Completion of onboarding modules via Workday
- \_\_\_\_\_ Contingent Worker/EPIC Request Form
- \_\_\_\_\_ Badge/ Parking form – Clinical instructors only
- \_\_\_\_\_ **For Clinical Students/Instructors:** AHA HCP BLS CPR Certification – Current (if non-clinical, print “N/A”)
- \_\_\_\_\_ **For Clinical Instructors Only:** Current WV license confirmed, all other requirements above met

By initialing this box and signing below, I declare that the information submitted is true and accurate, to the best of my knowledge. I attest that all students/instructors have completed the requirements set forth by the AA and that I am authorized by my organization to make this declaration. I understand that I am not required to sign electronically but must provide a signature for approval. I agree that my electronic signature legally binds me in the same manner as if I had signed in a non-electronic form and that electronic submission is legally enforceable as if the document was in its original form.

<b>Name &amp; Title:</b> _____	<b>Signature:</b> _____
<b>Email Address:</b> _____	<b>Phone Number:</b> _____