CABARRUS HEALTH ALLIANCE
INFORMATION FOR STUDENT AFFILIATION

Name: _____ DOB: _____

School: _____ Instructor:_____ Program _____

Dates or Days/Hours at agency: _____

Beginning Date: _____ Ending Date: _____

I certify that I:

_____Have submitted a copy of the learning objective(s) that I have for my clinical experience

_____Have proof of completion of Hepatitis B vaccination series

_____Have proof of Rubella, Rubeola, and Mumps immunity (vaccine or titer)

_____Have proof of Tetanus with Pertussis (Dtap)

_____Have statement of Varicella immunity (disease or immunization)

_____Have received training in universal precautions/bloodborne pathogens within past year

_____Have current certification in CPR (Basic Life Support)

_____Have professional or student liability insurance (school or personal)

_____Understand that I am to wear student ID and clinical uniform while at Cabarrus Health Alliance

_____Agree to follow Cabarrus Health Alliance policies and procedures regarding patient care and personnel policies during my clinical rotation

Date:_____ Signed:_____(Student)

Date:_____ Signed:_____(Instructor/Faculty)

For office use:

Date:_____ Signed:_____

Preceptor:_____ Site:_____

On file: ___Confidentiality statement ___Signature on file ___Professional license on file