

School: \_\_\_\_\_

Dates: \_\_\_\_\_



UCI Health – Los Alamitos | Placentia Linda | Fountain Valley | Lakewood

# Clinical Profile

**RETURN BY EMAIL TO Education Department**

## Instructions for Form Completion

1. The school is to contact the Education Department at the medical facility no later than **four weeks** prior to the start of the rotation for pre-planning, paperwork requirements and confirmation of rotation availability.
2. **Once availability is confirmed, the school must submit all required information listed below a minimum of three to four weeks before the requested start of each clinical rotation.**
3. Make sure to fill out the students' names on the second page.
4. All personnel (faculty and students) are required to verify current health screening/immunization compliance.
5. All paperwork is good for one rotation. Any subsequent rotations require a new set of paperwork to be submitted.

## Instructor and Rotation Information

School \_\_\_\_\_ Semester/Year \_\_\_\_\_

Clinical Instructor \_\_\_\_\_ Cell Phone \_\_\_\_\_

Program: ADN BSN MSN PA/FNP DO Other \_\_\_\_\_

Clinical Dates - From \_\_\_\_\_ To \_\_\_\_\_

(Note: Use exact date the students will be at the facility; these dates will be used to determine when the students will have computer access.)

Clinical Area \_\_\_\_\_ Clinical Day \_\_\_\_\_ Time \_\_\_\_\_

**Below are the requirements we must have from every Instructor and Student that rotates through UCI Health. Nobody will be able to be on site or start their rotation without submitting all the required items listed below.**

- Cover Letter (good standing) – Med and PA students only
- Packet Comprehension Test
- Attestation form
- UCI Confidentiality Agreement
- Sponsor form
- American Heart Association Healthcare Provider CPR/BLS
- Background check from within the last 12 months (must include checks for social security, OIG/GSA, criminal, sex offender)
- Urine Drug Screen (within past 12 months)
- Flu vaccination (required between 10/1 to 3/31) – including Manufacture and lot number **or** completed **UCI** Declination form
- MMR (proof of vaccination or recent titer)
- Varicella (proof of vaccination or recent titer)
- Current TB test (PPD or QuantiFERON within the past 12 months)
- Td/Tdap/DTap (within the past 10 years)
- Hep B (proof of vaccination or Hep B Antibody Quantitative)
- Page 126 from "2025 Privacy & Security Training" packet
- Instructors Only:** Nova Video Training Completion Certificate & in-person Competency
- Instructors Only:** Clinical Instructor Standards
- Instructors Only:** Medication Admin & Validating Medications Passed by Students Form
- Instructors Only:** Copy of current RN license

Printed Name and Title of person who is submitting the above required forms:

\_\_\_\_\_

Signature of person who is submitting the above required forms:

\_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_

Dates: \_\_\_\_\_

### Clinical Instructor and list of Students for this current rotation

Please Print or Type Clinical Instructor and Student Names below:

**CLINICAL INSTRUCTOR:**

NAME	EMAIL

**STUDENTS:**

	NAME
1	
	NAME
2	
	NAME
3	
	NAME
4	
	NAME
5	
	NAME
6	
	NAME
7	
	NAME
8	

DRAFT



UCI Health – Los Alamitos | Placentia Linda | Fountain Valley | Lakewood

## Sponsor Form

Return to Education Department

**\*\*\*Please type this information whenever possible.\*\*\***

*All areas must be completed. This information is used to create your computer access.*

**Are you a current UCI employee? Yes or No**

<b>First Name</b>	
<b>Middle Name</b>	
<b>Last Name</b>	
<b>Full SS Number</b>	
<b>Full Date of Birth (mm/dd/yyyy)</b>	
<b>Phone number</b>	
<b>School Email Address</b>	
<b>School Name</b>	

Access Type:  ADN  BSN  MSN  PA/FNP  DO/Med Other \_\_\_\_\_

<b>Facility</b>	UCI Health – Los Alamitos   Placentia Linda   Fountain Valley   Lakewood
<b>Department</b>	Education
<b>Leader Sponsoring Access</b>	Shanna Rushing
<b>Reason for Access</b>	Patient Chart Review

**Security Statement**

Computer access privileges are granted by UCI Health at the lowest possible level pursuant to the efficient performance of the approved duties and must be used only for UCI Health authorized business. Computer access devices, such as user identity codes and passwords, remain the property of UCI Health and are not to be divulged to any other person unless approved by Perot Systems Security. Unauthorized access to, use and possession of, removal of, and/or damage to company records is a breach of the UCI Health policy and may result in disciplinary and/or legal action. I agree to keep my access code confidential and to guard the confidentiality of all system information. I share responsibility for the protection of UCI Health's information assets and will be held accountable for maintaining their integrity, confidentiality, and availability. Violation of this policy will be grounds for disciplinary action, up to and including termination. UCI Health reserves the right to pursue legal prosecution under local, state, and federal statutes. I have read and understood the content of the above Security Statement and agree to accept and abide by the policies stated herein. **Initial here → \_\_\_\_\_**

**For Facility Use Only:**

- Cover Letter (good standing) Med and PA students only
- Packet Comprehension Test \_\_\_\_\_%
- Attestation Form
- UCI Confidentiality Agreement
- Sponsor form
- AHA Healthcare Provider BLS \_\_\_\_\_
- Background check from w/i last 12 months (inc social security, OIG/GSA, criminal, sex offender) \_\_\_\_\_
- Flu vaccination (required between 10/1 to 3/31) Inc. Mfr. name and lot # or UCI Declination form \_\_\_\_\_
- MMR (proof of vaccination or recent titer)
- Varicella (proof of vaccination or recent titer)
- TB test (PPD or QuantiFERON w/i past 12 mo) \_\_\_\_\_
- Td/Tdap/DTap (within the past 10 years) \_\_\_\_\_
- Hep B (proof of vaccination or Hep B Antibody Quantitative)
- Urine Drug Screen (within the past 12 months)
- Page 126 from "2025 Privacy & Security Training" packet
- Instructor:** Nova Video Training & Competency
- Instructor:** Clinical Instructor Standards
- Instructor:** Med Admin & Valid Med Students form
- Instructor:** Copy of current RN license \_\_\_\_\_

\_\_\_\_\_  
Signature Not a Digital Signature

\_\_\_\_\_  
Date



**CONFIDENTIALITY AGREEMENT  
UC IRVINE HEALTH**

*Applies to all UC Irvine Health “workforce members” including: employees; medical staff and other health care professionals; volunteers; agency, temporary and registry personnel and trainees; house staff, students and interns (regardless of whether they are UC Irvine trainees or rotating through UC Irvine Health facilities from another institution).*

It is the responsibility of all UC Irvine Health workforce members, as defined above, including employees, medical staff, house staff, students and volunteers to preserve and protect confidential patient, employee and business information.

The federal Health Insurance Portability and Accountability Act (the “Privacy Rule”), the Confidentiality of Medical Information Act (California Civil Code § 56 et seq.), and the Lanterman- Petris-Short Act (California Welfare & Institutions Code § 5000 et seq.) govern the release of patient identifiable information by hospitals and other health care providers. The State Information Practices Act (California Civil Code sections 1798 et seq.) governs the acquisition and use of data that pertains to individuals. All of these laws establish protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

***Confidential Patient Care Information includes:*** Any individually identifiable information in possession of or derived from a provider of health care regarding a patient’s medical history, mental or physical condition or treatment, as well as the patients’ and/or their family members’ records, test results, conversations, research records, and financial information. (Note: this information is defined in the Privacy Rule as “protected health information”.) Examples include, but are not limited to:

- Electronic and paper medical and psychiatric records including photos, videos, diagnostic results, therapeutic reports, and laboratory and pathology samples;
- Patient insurance and billing records; Department
- based computerized patient data; Alphanumeric
- radio pager messages;
- Visual observations of patients receiving medical care or accessing services; and Verbal
- information provided by or about a patient.

***Confidential Employee and Business Information includes, but is not limited to the following:***

- Employee home telephone number and address;
- Spouse or other relative names;
- Social Security number or income tax withholding records; Information
- related to evaluation of performance;
- Other such information obtained from the University’s records which if disclosed, would constitute an unwarranted invasion of privacy;
- Peer Review and risk management activities and information are protected under California Evidence Code Section 1157 and the attorney client privilege; or
- Disclosure of confidential business information that would cause harm to UC Irvine Health.

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.
2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to UC Irvine Health and its affiliates, including business, employment and medical information relating to our patients, members, employees and health care providers.
3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of UC Irvine Health, or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosures of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of UC Irvine Health affairs.
4. UC Irvine Health Administration performs audits and reviews patient records in order to identify inappropriate access.
5. My user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.
6. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss information outside of the work place or within hearing of other people who do not have a need to know about the information.
7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies of antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.
8. I understand that the law specifically protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.
9. My obligation to safeguard patient confidentiality continues after I am no longer a UC Irvine Health workforce member.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. I understand that violation of this Agreement may result in violation of state and/or federal law, and may subject me to disciplinary action, up to and including termination from employment or affiliation with the University of California, and possible criminal and/or civil action.

Dated: \_\_\_\_\_ Signature: \_\_\_\_\_

Not a Digital Signature

Department: \_\_\_\_\_ Print Name: \_\_\_\_\_

## ATTESTATION FORM

I have reviewed the following topics:

- Hospital Mission and Vision
- Student Health and Injury Prevention
- Body Mechanics/Office Ergonomics
- OSHA Bloodborne Standards
- Isolation Precautions/Universal Precautions
- Organizational Ethics
- Safety & Quality Information System (SQIS)
- Patient Privacy/HIPAA/Compliance
- Patients' Rights and Responsibilities
- Social Services/ADA/Interpreter Services
- Abuse/Neglect Screening and Reporting
- Advanced Directives
- EMTALA
- Utilization Management
- Age/Cultural Diversity & Sensitivity
- Healthcare Disparities
- Pain Management
- Falls Prevention
- Restraints
- End of Life Care/Pastoral Care
- Disruptive Provider Behavior
- Complaint/Grievance Process
- Bioethical Issues
- Rapid Response/Code Blue
- Spot a Stroke – BE FAST
- Chain of Command to Obtain Medical Care
- Patient Medical Safety
- Safety Management Plan
- Patient Safety Bands
- Performance Improvement Plan/PDCA
- HCAHPS
- AIDET
- Employee Customer Service Standards
- Regulatory Agencies and Core Measures
- Quality/Risk Management/Patient Grievances
- National Patient Safety Goals/Clinical Alarms
- Organ Procurement
- Fire Safety and Emergency Codes
- UCI Health Environment of Care
- Radiation/Electrical Safety
- Utilities Management
- Medical Equipment/Biomedical Equipment
- Security Management
- Workplace Violence
- Hazardous Waste/Safety Data Sheets
- OSHA Hazard Symbols
- Waste Disposal
- PolicyStat
- Infection Prevention/COVID/Emerging Infections
- Hand Hygiene/Personal Protective Equipment
- Verification of Physician Privileges

I know I am able to further discuss these topics as needed to answer any questions I may have.

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**Name (Please print)**

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**Department**

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**Date**

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**Signature (Not a digital signature)**

***Your signature indicates that you will review/have reviewed the above information and are responsible for adhering to its contents.***

## Packet Comprehension Test

Name: \_\_\_\_\_ School: \_\_\_\_\_ Score: \_\_\_\_\_

(Please print)

Choose the **best** answer for each test question. You must have a passing score of 100%.  
All answers to the test can be found in these Onboarding Documents.

1. The mission of UCI Health is to “Discover. Teach. Heal.”
  - a. True
  - b. False
2. All healthcare personnel are mandated reporters of:
  - a. Elder abuse
  - b. Child abuse
  - c. Domestic Violence
  - d. All of the above
3. Healthcare personnel must wash/gel hands:
  - a. Before putting on gloves.
  - b. After removing gloves.
  - c. Before donning PPE (Personal Protective Equipment).
  - d. All of the above.
4. You have a temperature of 99.5, a sore throat and muscle aches. You have a clinical rotation day scheduled. What should you do?
  - a. Wear an N-95 mask and gloves during your time on the patient care unit.
  - b. Take acetaminophen and drink plenty of fluids to get you through your shift.
  - c. Notify your Clinical Instructor that you are sick and stay home.
  - d. Notify the Employee Health Nurse that you are ill.
5. You need to protect yourself from all bodily fluids, from all patients, at all times by utilizing standard precautions.
  - a. True
  - b. False

### Answers:

- 1)  T  F
  - 2)  A  B  C  D
  - 3)  A  B  C  D
  - 4)  A  B  C  D
  - 5)  T  F
  - 6)  A  B  C  D
  - 7)  A  B  C  D
  - 8)  A  B  C  D
  - 9)  A  B  C  D
  - 10)  A  B  C  D
  - 11)  T  F
  - 12)  A  B  C  D
  - 13)  A  B  C  D
  - 14)  A  B  C  D
  - 15)  A  B  C  D
  - 16)  A  B  C  D
6. The patient you are assigned to care for today has a difficult to pronounce name. How should you address him?
    - a. Call him “sir.”
    - b. Ask him how he would like to be addressed.
    - c. Call him Papa.
    - d. Avoid using any name.
  7. What tool helps you establish a relationship with your patient?
    - a. BEFAST
    - b. AIDET
    - c. RELATING
    - d. LOVE

8. A fire alarm sounds in the hospital. You are in your patient's room. What should you do first?
  - a. Close the patient's door.
  - b. Ignore the alarm – it is probably a drill.
  - c. Grab a "C" class fire extinguisher and look for the fire.
  - d. Open the patient window so if smoke enters the room, you will be able to breathe.
9. To report an emergency in UCI Health-Fountain Valley, you would use a hospital phone to dial:
  - a. 5
  - b. 55
  - c. 555
  - d. 5555
10. Healthcare personnel can share patient information they overhear at work if:
  - a. The patient is a relative.
  - b. The patient is a friend.
  - c. The patient is famous or a celebrity.
  - d. Their healthcare role requires them to share.
11. You are permitted to use a personal cell phone to take and transmit a picture of a patient's surgical incision to a physician.
  - a. True
  - b. False
12. All patients need to be assessed for their risk of falling. One of the tools used to assess risk of falling is the:
  - a. Braden Scale
  - b. Wagner Grading System
  - c. Morse Scale
  - d. Bristol Scale
13. You are caring for a patient that has a purple arm band. This purpose of this band is to alert you that:
  - a. The patient has dialysis three days a week.
  - b. The patient has an order of "Do not resuscitate."
  - c. The patient had packing placed in a wound during surgery.
  - d. The arm is not to be used for Laboratory blood draws.
14. The patient you are caring for speaks only Spanish and is being discharged. Since you are fluent in Spanish and the Primary Care RN is not, he asks you to give the patient their discharge instructions. What do you do in this situation?
  - a. Provide the discharge instructions for the Primary Care RN.
  - b. Have your Clinical Instructor in the room when you provide the instructions.
  - c. Utilize the video remote interpretation devices that are located on the patient care units.
  - d. Give the discharge instructions to the family in English and they can interpret for the patient.
15. Your patient is in respiratory distress with a respiratory rate of 32 and the pulse oximetry reading is 89. What should you do?
  - a. Try to find the Clinical Instructor so he can guide you.
  - b. Call a Code Blue.
  - c. Call a Rapid Response.
  - d. Find the Primary Care RN and ask her what to do.
16. A patient has sudden onset of garbled speech. What Neuro assessment tool can **you** use to determine if this is a possible stroke?
  - a. RACE
  - b. BE FAST
  - c. NIHSS
  - d. MEND



## Influenza Vaccination ~~Authorization~~ / Declination

The University of California recommends that all members of the community, except those who have medical contraindications, receive a vaccination to protect against influenza (flu) during flu season. I understand that:

According to the Centers for Disease Control & Prevention (CDC), vaccination against the seasonal respiratory disease influenza or “flu” has long been accepted as a safe and effective way to prevent millions of illnesses and thousands of related doctor and hospital visits every year. Flu vaccination in adults substantially reduces the risk of severe illness. By getting vaccinated, a person can also protect those around them, including those who are more vulnerable to serious flu illness.

For the 2025-2026 influenza season, the CDC recommends routine annual influenza vaccination for all persons 6 months or older without a contraindication to vaccination to protect against influenza and its complications.

~~I ACCEPT THE OFFER OF INFLUENZA VACCINATION~~

~~I have been given/offered the Influenza Vaccine Information Statement (VIS) Vaccine Information Statement: Inactivated Influenza Vaccine. I understand the risks and benefits of the influenza vaccine and request that it be given to me. By my signature below, I affirm all the above statements.~~

~~CONSENT QUESTIONS~~

- ~~1. Have you ever experienced an anaphylactic/allergic/severe reaction to the influenza vaccine?  Yes  No~~
- ~~2. Have you ever had Guillain-Barre syndrome?  Yes  No~~
- ~~3. Have you had a fever of 100.4 F or above in the last 24 hours?  Yes  No~~

I DECLINE THE INFLUENZA VACCINATION AT THIS TIME

By submitting my declination, I acknowledge that:

- a. I have read and understand the information provided in this informed declination.
- b. I have had the full opportunity to ask questions concerning the vaccine and have received satisfactory answers to my questions.
- c. I **DO NOT** agree to have the vaccine as recommended.
- d. I understand that I can change my mind at any time and accept the flu vaccine.
- e. I understand that as long as I refuse to accept the flu vaccine, I will be required to wear a mask at all times while at UCI Health and affiliated clinics all year around (as defined by UCI Health policy).

I am choosing to decline the flu vaccine for this primary reason:

- I have a medical contraindication that would result in a severe allergic reaction to an ingredient in a flu vaccine (other than egg proteins and/or latex) or have had a reaction to prior flu vaccines.  
Note: flu vaccine formulations are currently available without egg proteins or latex
- I have a history of Guillain-Barre syndrome
- Disability
- Religious Belief
- Personal Belief
- Prefer Not to Answer
- Other: \_\_\_\_\_

Name (Print):	
Signature:	Date:
Manufacturer: (Circle one) GSK <b>SPI</b> PSC	Lot Number: