WELCOME TO THE ADN PROGRAM

Cape Fear Community College's Associate Degree Nursing Faculty and Staff welcome you to what will be one of the most challenging and exciting times of your career. In order to ensure you start the semester with all the required documentation, we have put together a checklist of what will be required by the date given at Orientation.

Admitted, returning, transfer and transition students must have the following turned in to the Health Sciences Secretary by the date given at Orientation or they will not be permitted to attend:

1. CPR Proof - must be current two-year CPR certification for health care providers (must include infant, child and adult). No online courses accepted.
2. Liability Insurance (when entering/re-entering during a spring or summer session, students will be informed when they need to go pay)
3. Demographic Form
4. Policy Statement
5. CFCC ID Badge – Must state "ADN Student" on badge
6. Drug Screen (9 panel) (Information to be distributed at Orientation)
7. Immunization Proof (Not required for returners)
8. Hepatitis B Proof Or Declining Statement (Not required for returners)
9. Physical, including hearing and vision (Not required for returners)
10. Criminal Background Check – www.certifiedbackground.com. Enter the package code AY42. Cost varies per student. (Not required for returners)
11. Syllabus – Purchase in bookstore before first class. **Each semester** students must have a syllabus in order to enter class the first day.
12. *Online Orientation – http://www.nhrmc.net/Orientation_Online Complete each section prior to completing test.
13. *Confidentiality Statement & Code Of Conduct Statement (Read Code of Conduct (NHRMC) prior to signing)
14. *Confidentiality Statement
15. *Corporate Compliance Quiz (Read Corporate Compliance Training (NHRMC) information prior to completing the post quiz)
16. Student Agreement

*Copy of NHRMC name badge waives this item.

Contact Health Sciences Secretary Donna Breedlove at 362-7655 if you have questions.

Cape Fear Community College
Associate Degree Nursing Program
Student Demographic Data Form

INFORMATION:

1. This questionnaire provides data for the department of nursing curriculum development. An ongoing assessment of the people for whom the curriculum is devised (student characteristics and demographic data) constitutes one of the most essential and basic factors for curriculum change.

2. All data are confidential and will be used for curriculum study purposes and to meet the needs of the students.

3. Thank you for helping in the curriculum study.

DIRECTIONS:

1. Circle the number of the answer that applies to you.
2. Fill in blanks where blanks are provided.
3. Please print clearly.

Date: _____/_____/_____ CFCC Student ID # _____

Name:_____ SS # : _____/____/_____

Address:_____

City:_____State:_____ Zip Code:_____

Telephone Number: (_____)_____Other/Cell Phone: (_____)_____

Closest Relative:_____ Relationship:_____

Telephone Number: (_____)_____

Email Address:_____

1. Sex: Male: _____ Female: _____

2. Ethnicity: _____

1. White, non-Hispanic
2. Black (African-American), Non-Hispanic
3. American Indian or Alaskan Native
4. Asian or Pacific Islander
5. Hispanic (all races)
6. Multi-racial heritage
7. Race/ethnicity unknown

3. Educational Level Completed: _____

1.	High School Graduate	3.	AD	5.	Masters
2.	GED	4.	BS		

4. Marital Status: _____

1.	Single	3.	Divorced	5.	Separated
2.	Married	4.	Widowed		

5. Age:_____ Birthdate:_____

6. Number of Children:_____

7. How far do you travel to school each day (ONE WAY): Miles:_____

8. Current work hours per week: _____

9. Previous Healthcare experience: _____

1.	No experience	3.	CNA	5.	Other _____
2.	EMT	4.	LPN or LVN		

10. Are you *transitioning* in from LPN? Yes_____ No_____

11. Are you *returning* to the ADN program? Yes_____ No_____

12. Are you *transferring* from another ADN program? Yes _____ No _____

13. Please select your US citizen status:

☐ US citizen ☐ resident alien ☐ non-resident alien ☐ unknown

Thank you for your cooperation!!

ADN STUDENT POLICY ACKNOWLEDGEMENT

NAME OF STUDENT: _____

DATE RECEIVED: _____

I have been given a copy of the Policies for the Associate Degree Nursing Program of Cape Fear Community College. I have read these Policies myself in their entirety and have had my questions answered. I understand and agree that, as a student in the Associate Degree Nursing Program of Cape Fear Community College, I am bound and responsible to comply with all of these Policies. I also understand and agree that I am subject to all of the requirements, provisions, and procedures contained in these Policies.

_____

Signature of Student

Date returned:_____

Cape Fear Community College
Hepatitis B Vaccine Consent/ Declination Form

PLEASE READ CAREFULLY (Complete the section that describes you)

1. I choose to take the Hepatitis B Vaccine. I have read and understand the information on this form about the Hepatitis B Vaccine. I have had a chance to ask questions which were answered to my satisfaction. I agree to accept the responsibility of any/all side effects that may happen by taking the Hepatitis B Vaccine.

	Dose	Date	Signature
_____ Student Signature	1st -		
	2nd -		
_____ Witness	3rd -		
_____ Date			

---

2. I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk for acquiring Hepatitis B Virus (HBV) Infection. I have been advised to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I will receive the vaccination series at my own expense.

_____
Declining Student

_____
Witness

_____
Date

****

3. I have already received 3 doses of Hepatitis B vaccine at

_____ during _____
(Location) (Year)

_____ _____
Student Signature Witness

_____
Date

New Hanover Regional Medical Center

Confidentiality Statement & Code of Conduct Acknowledgment

While I am employed by, working on behalf of or studying within New Hanover Regional Medical Center:

1. I will respect the privacy and confidentiality of our patients, employees, and organization by following hospital policies and procedures regarding access and/or release of patient health information.

2. I will not verbally or in any written form disclose any type of confidential patient health information (including electronic patient health information) to any unauthorized person or permit any unauthorized person to examine or duplicate of any patient's records, reports, other documents, or data files prepared, controlled, or accessible by me at any time during or after my employment or work at NHRMC.

3. I will not examine, use, or disclose confidential patient health information except as needed to perform the duties of my job.

4. If I am in NHRMC as a student or instructor I understand that I will have limited access to information and I will not access or utilize information beyond that scope. I also understand that all patients' health information is the property of NHRMC and this information may not be audio taped, photographed, videotaped, photocopied or taken off the property without appropriate release by the Health Information Management Department.

5. I will not discuss patient health information with persons within NHRMC in locations where other staff or visitors may overhear the discussion (even if the patient name is not used). These locations may include but not be limited to elevators, dining areas, lounges, and hallways when others are present.

6. When visitors are present, I will ensure that confidential patient health information is not visible (such as hard copy or electronic display) in order to protect from unnecessary disclosure.

7. I understand that all patients' records are the property of NHRMC and these records (in hard copy or electronic form) may not be taken off the property without appropriate release by the Health Information Management Department.

8. I understand that any information about the business, customers, patients and pricing of the hospital is the property of NHRMC. I also understand that the business of NHRMC and its affiliates is confidential and is not to be discussed with persons outside of the system.

9. Any electronic media (such as CDs, DVDs, or disks) containing PHI should be purged of the PHI after processing of the data or turned in to Information Services for appropriate destruction. Hard copy reports and papers containing PHI should be placed in the nearest shredder bin at time of disposal.

10. I will take the proper precautions when using the fax machine.

I further understand that violations of patient confidentiality policies may result in disciplinary action, up to and including discharge. In addition, persons violating patient confidentiality practices may be subject to civil and criminal liability.

I certify that I have received the **Code of Conduct** and understand that compliance with the Code of Conduct & this **Confidentiality Statement** is a condition of my employment with New Hanover Regional Medical Center. I understand that the Code of Conduct is to be used as a guide and that more detailed instructions can be found in the medical center's policies and procedures. I accept this responsibility and understand that a violation of any policy can result in disciplinary action, up to and including discharge. I certify that I have been briefed on the content and importance of the **Non-Retribution/ Non-Retaliation Policy**.

Print Name	Date
Signature	___-XX-XX___ Social Security Number (First 3 digits & Last 2)
Department	Position

New Hanover Regional Medical Center

Confidentiality Statement

While I am employed by, working on behalf of or studying within New Hanover Regional Medical Center:

1. I will respect the privacy and confidentiality of our patients, employees, and organization by following hospital policies and procedures regarding access and/or release of patient health information.

2. I will not verbally or in any written form disclose any type of confidential patient health information (including electronic patient health information) to any unauthorized person or permit any unauthorized person to examine or duplicate of any patient's records, reports, other documents, or data files prepared, controlled, or accessible by me at any time during or after my employment or work at NHRMC.

3. I will not examine, use, or disclose confidential patient health information except as needed to perform the duties of my job.

4. If I am in NHRMC as a student or instructor I understand that I will have limited access to information and I will not access or utilize information beyond that scope. I also understand that all patients' health information is the property of NHRMC and this information may not be audio taped, photographed, videotaped, photocopied or taken off the property without appropriate release by the Health Information Management Department.

5. I will not discuss patient health information with persons within NHRMC in locations where other staff or visitors may overhear the discussion (even if the patient name is not used). These locations may include but not be limited to elevators, dining areas, lounges, and hallways when others are present.

6. When visitors are present, I will ensure that confidential patient health information is not visible (such as hard copy or electronic display) in order to protect from unnecessary disclosure.

7. I understand that all patients' records are the property of NHRMC and these records (in hard copy or electronic form) may not be taken off the property without appropriate release by the Health Information Management Department.

8. I understand that any information about the business, customers, patients and pricing of the hospital is the property of NHRMC. I also understand that the business of NHRMC and its affiliates is confidential and is not to be discussed with persons outside of the system.

9. Any electronic media (such as CDs, DVDs, or disks) containing PHI should be purged of the PHI after processing of the data or turned in to Information Services for appropriate destruction. Hard copy reports and papers containing PHI should be placed in the nearest shredder bin at time of disposal.

10. I will take the proper precautions when using the fax machine.

I understand that compliance with this **Confidentiality Statement** is a requirement for access to the EPIC application, therefore impacting my employment and/or functionality within New Hanover Regional Medical Center. I accept this responsibility and understand that a violation of this statement can result in disciplinary action, up to and including discharge, and/or termination of access rights. I further understand that violations of patient confidentiality policies may result in disciplinary action, up to and including discharge. In addition, persons violating patient confidentiality practices may be subject to civil and criminal liability.

Print Name	Date
Signature	___-XX-XX___ Social Security Number (First 3 digits & Last 2)
Department	Position

Compliance Training Post-Quiz

1.	**NHRMC's Code of Conduct provides general guidelines and educates staff on the relevance of compliance throughout the hospital.**	❑ **TRUE**	❑ **FALSE**
2.	**Billing for services or supplies that were not provided is an example of a compliance issue that should be reported.**	❑ **TRUE**	❑ **FALSE**
3.	**NHRMC's guiding principle is that when you become aware of something you believe to be improper, you should report it!**	❑ **TRUE**	❑ **FALSE**
4.	**Employees should never accept monetary gifts or tips from patients or their families.**	❑ **TRUE**	❑ **FALSE**
5.	**An employee should never access patient health information except as needed to perform his/her job.**	❑ **TRUE**	❑ **FALSE**
6.	**Patient health information that is accessed electronically is <u>not</u> monitored.**	❑ **TRUE**	❑ **FALSE**
7.	**A patient's detailed condition information may be released over the phone with proper written authorization by the patient, which includes a list of individuals the patient wants to receive his/her detailed condition information and a code word.**	❑ **TRUE**	❑ **FALSE**
8.	**Violation of patient confidentiality policies may result in disciplinary action, up to and including discharge.**	❑ **TRUE**	❑ **FALSE**
9.	**Portable Telecommunication Devices for the Deaf (TDDs) are available on the 17th Street Campus on floors 2, 4, 6, 8, 10, & Switchboard, and on the CF Campus at the Switchboard.**	❑ **TRUE**	❑ **FALSE**
10.	**Reports or concerns made through the Compliance Hotline are <u>not</u> investigated.**	❑ **TRUE**	❑ **FALSE**

Print Name _____ Date _____

Signature _____ Employee Badge Number _____

Department _____ Position _____

New Hanover Regional Medical Center

STUDENT AGREEMENT

In consideration for participating in the _____clinical education training program (the "Program") at New Hanover Regional Medical Center (the "Hospital"), I hereby agree to the following:

1. To follow the administrative policies, standards and practices of the Hospital when in the Hospital.

2. To report to the Hospital on time and to follow all established rules and regulations of the Hospital.

3. To keep in confidence all medical, health, financial and social information (including mental health) pertaining to any Hospital client or patient and to abide by all State and federal laws governing the confidentiality of patients' or clients' health information.

4. To comply with all federal, state and local laws regarding the use, possession, manufacture or distribution of alcohol and controlled substances.

5. To follow Centers for Disease Control and Prevention (the "CDC") Universal Precautions for Bloodborne Pathogens, CDC Guidelines for Tuberculosis Infection Control, and Occupational Safety and Health Administration ("OSHA") Respiratory Protection Standards.

6. To provide the necessary and appropriate uniforms and supplies required where not provided by the Hospital.

7. To wear a name tag that clearly identifies me as a Student of the Program as supplied by _____ Educational Institution (the "Educational Institution").

Further, I understand and agree that I will not receive any monetary compensation from the Educational Institution or the Hospital for any services I provide to the Hospital or its clients, students, faculty or staff as a part of the Program.

I also understand and agree that I shall in no way be deemed to be an employee, agent, or servant of the Educational Institution or the Hospital and that I will not in any way hold myself out as an employee, agent or servant of the Educational Institution or Hospital.

I understand that all patients' health information is the property of hospital and this information may not be audio taped, photographed, videotaped, or photocopied or taken off the property without appropriate release by the Medical Records Department.

I understand and agree that I may be immediately withdrawn from the Program for a lack of competency, failure to comply with the rules and policies of the Hospital or Educational Institution, posing a direct threat to the health or safety of others or, for any other reason the Hospital or the Educational Institution reasonably believes that it is not in the best interest of the Educational Institution, the Hospital or the Hospital's patients or clients for me to continue. In the event I am to be withdrawn from the Program, I will be provided with notice of the withdrawal and the reasons for it.

I understand and agree to carry professional liability insurance covering my activities at the Hospital in amounts satisfactory to the Hospital (currently One Million Dollars ($1,000,000) per occurrence, Three Million Dollars ($3,000,000) in the aggregate) and the Educational Institution and to provide evidence of such insurance upon request.

I further understand that all medical or health care (emergency or otherwise) that I receive at the Hospital will be my sole responsibility and expense.

By signing this Agreement, I hereby indemnify (to the extent permitted under the North Carolina Tort Claims Act, N.C.G.S 143-291 et seq. and without waiving sovereign immunity) and hold harmless New Hanover Regional Medical Center and its members, agents, servants and employees (each of the foregoing hereinafter referred to individually as the "Indemnified Party") against all claims, demands, causes of action, actions, judgments, or other liability including attorney's fees (other than liability solely the fault of the Indemnified Party) arising out of or in connection with this Agreement.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this Agreement; and that I, or my parent and/or guardian, have read carefully and understand the above Agreement; and that I have freely and voluntarily signed this "Agreement".

This the __ day of _____ 200__.

_____ _____

Signature Witness Signature

Name:_____ Name:_____

(Please print) (Please print)

_____ _____

Parent/Guardian Signature Witness Signature

(if applicable)

Name:_____ Name:_____

(Please print) (Please print)