CMH Community Memorial Hospital

Student Experience Application

Thank you for your interest in gaining valuable health care experience at Community Memorial Hospital. We believe strongly in partnering with individuals to provide meaningful educational experiences to students interested in entering the healthcare field.

CMH Policy Requirements

Job Shadows and Short Term Experiences (less than 10 hrs/week and less than 1 month):

- Applicant must be entering their freshman year of high school or later.
- HIPAA Training and Violence Against Health Care Workers (every other Tuesday of each month from 10-11:30am in the Pine Room (CMH ground floor).
- Proof of flu shot needs to be provided to CMH by applicants if experience will take place between October 1 and March 31, annually.

Interns or Long Term Experiences (over 10 hrs/week or for more than 1 month):

- Applicant must be entering their freshman year of high school or later.
- HIPAA and Violence Against Health Care Workers training (every other Tuesday of each month from 10-11:30am in the Pine Room (CMH ground floor).
- Proof of flu shot needs to be provided to CMH by applicants if experience will take place between October 1 and March 31, annually.
- School or entity affiliated with applicant <u>must have a contract on file with CMH</u>.
  - Contract indicates immunizations and 2 step-Mantoux (TST) or T-spot/Quantiferon have been done and are on file with school or entity prior to experience scheduled, and will be available to be sent to CMH if requested.

Complete this form and email a copy to jschultz@cloquethospital.com or mail the printed form to: CMH Student Experience / ATTN: Jordan Schultz, 512 Skyline Blvd, Cloquet, MN 55720. For more information call 218-878-7073.

Part 1: Contact Information (please print or complete on computer)

First name: ______________________ Last name: ______________________

Address: ____

City: ______________________ State ____________ Zip Code: ______________

E-Mail: ____

Phone: ______________________ Cell: ______________________

Part 2: Experience Request

Are you a current CMH employee? Yes No

Which type of request are you interested in? Job Shadow/Short Term Experience Intern/Long Term Experience

Do you already know someone, or have you been in touch with a CMH employee for this request? Yes No

If yes, please provide: Employee's Name and Department ______________________

Please provide your preferred <u>dates/times</u> for the experience to take place and the <u>area/department</u> you are interested in.

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By signing your name below, you are acknowledging that you understand and meet the requirements listed above for the experience you are requesting and will attend a HIPAA/VAHCW training session as required by CMH.

______________________ ____________

Applicant Signature Date