

**Avera Heart Hospital of South Dakota Student Experience Application**



**Student Information:**

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Educational Institution:** \_\_\_\_\_

**Program Enrolled In:** \_\_\_\_\_ **Start date:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_

**Emergency Contact Name and Phone:** \_\_\_\_\_

**Area you are requesting to observe:** \_\_\_\_\_

**Please give 3 dates that you are available. We will attempt to accommodate one of the requested dates:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Observation Sponsor (AHH employee or NCH physician who will be facilitating this experience:**

\_\_\_\_\_

**By my signature below, I confirm that I have read, understand and agree to adhere to the conditions and policies of an Avera Heart Hospital of South Dakota rotation/observation experience.**

- I understand that information I see and hear about patient identity and conditions is considered confidential and is not to be discussed outside of my experience. Any violation of patient or hospital confidentiality will result in dismissal from the experience.
- I hereby agree that I will not disclose to anyone information concerning patients and patients' family members which I may acquire during the experience.
- Avera Heart Hospital will take immediate action in any situation in which my behavior or performance adversely affects the best interests of the facility or patients. This action may include, but is not limited to, my removal from the facility and the experience.
- Avera Heart Hospital is not responsible for lost or stolen personal belongings.
- I will hold Avera Heart Hospital and its employees harmless in the event of incident, injury or illness. Avera Heart Hospital is not responsible for costs involved with emergency or follow-up care. I will call the facility and cancel, in advance, my experience if I suspect I may be ill.
- I understand that utilization of personal electronic devices is strictly prohibited.
- I understand that if I am pregnant or may be pregnant I will not be permitted to observe in any area in which I may be exposed to radiation. It is my responsibility to disclose this information.
- On the day of your student experience please refrain from using perfume, cologne or lotions with fragrances.

**I agree to provide AHHSd with the required health documentation PRIOR to my experience. See attachment.**

**Participant Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\*Return completed application, confidentiality statement, and immunizations to Amber Barron at [amber.barron@avera.org](mailto:amber.barron@avera.org)