APPLICATION FOR CLINICAL OBSERVERS - University of California, San Francisco

SECTION 1: ***To be completed by student and authorized official of student's school. Please return all copies to the Department of Orofacial Sciences, University of California San Francisco, Attn: Judy Huang, 513 Parnassus Ave. Rm S-612, San Francisco, California 94143-0422. Please bring a $500 check made payable to UC Regents upon arrival to cover processing fees.***

TO: Judy Huang
Division of Pediatric Dentistry
Department of Orofacial Sciences

I would like to apply for an externship in your department

during the period _____to_____, 20_____.

STUDENT'S NAME:_____
(Print or Type) Mailing Address

_____
City/State Zip Code Telephone E-mail

To be completed by Dean or authorized official of student's dental school.

The student named above is a _____year dental student in good standing at this institution.

The student will pay tuition at this school during the period indicated.

Evidence of malpractice insurance (to cover the period of the elective) of at least 1 million dollars per occurrence must be enclosed with this application (not applicable for UCLA).

Evidence of health insurance coverage (to cover the period of the elective) must be enclosed with this application (not applicable for UCLA).

The student is authorized to take this elective.

At the conclusion of the experience, a report WILL_____WILL NOT_____be required.

AUTHORIZED BY (Signature):_____Date:_____

Name (Print or Type):_____Title: _____

Name of School:_____

Address:_____

STATEMENT OF PRIVACY LAWS AND UNIVERSITY POLICY

It is the legal and ethical responsibility of all UCSF faculty, staff, house staff, students, trainees, volunteers, and contractors to use, protect, and preserve personal and confidential patient, employee, and University business information, including medical information for clinical or research purposes (referred to here collectively as "Confidential Information"), in accordance with state and federal laws and University policy.

Laws controlling the privacy of, access to, and maintenance of confidential information include, but are not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), the HIPAA Final Omnibus Rule, the California Information Practices Act (IPA), the California Confidentiality of Medical Information Act (CMIA), and the Lanterman- Petris-Short Act (LPS). These and other laws apply whether the information is held in electronic or any other format, and whether the information is used or disclosed orally, in writing, or electronically.

University policies that control the way confidential information may be used include, but are not limited to, the following: UCSF Medical Center Policies 05.01.04 and 05.02.01, LPPI Policies, UCSF Policy 650- 16 Minimum Security Standards, UC Personnel Policies PPSM 80 and APM 160, applicable union agreement provisions, and UC Business and Finance Bulletin RMP 8.

"Confidential Information" includes information that identifies or describes an individual, the unauthorized disclosure of which would constitute an unwarranted invasion of personal privacy. Examples of confidential employee and University business information include home address, telephone number, medical information, date of birth, citizenship, social security number, spouse/partner/relative names, income tax withholding data, performance evaluations, proprietary/trade secret information, and peer review/risk management information and activities.

"Medical Information" includes the following no matter where it is stored and no matter the format: medical and psychiatric records, photos, videotapes, diagnostic and therapeutic reports, x-rays, scans, laboratory and pathology samples, patient business records (such as bills for service or insurance information), visual observation of patients receiving medical care or accessing services, and verbal information provided by or about a patient. Medical information, including Protected Health Information (PHI), is maintained to serve the patient, health care providers, health care research, and to conform to regulatory requirements.

Unauthorized use, disclosure, viewing of, or access to confidential information in violation of state and/or federal laws may result in personal fines, civil liability, licensure sanctions and/or criminal penalties, in addition to University disciplinary actions.

University Privacy Policy and Acknowledgement of Responsibility

I understand and acknowledge that:

- It is my legal and ethical responsibility as an authorized user to preserve and protect the privacy, confidentiality and security of all confidential information relating to UCSF, its patients, activities and affiliates, in accordance with applicable laws and University policy.
- I will access, use or disclose confidential information only in the performance of my University duties, when required or permitted by law, and disclose information only to persons who have the right to receive that information. When using or disclosing confidential information, I will use or disclose only the minimum information necessary.
- I will discuss confidential information for University-related purposes only. I will not knowingly discuss any confidential information within hearing distance of other persons who do not have the right to receive the information. I will protect confidential information which is disclosed to me in the course of my relationship with UCSF.
- Special legal protections apply to and require specific authorization for release of mental health records, drug abuse records, and any and all references to HIV testing, such as clinical tests, laboratory or others used to identify HIV, a component of HIV, or antibodies or antigens to HIV. I will obtain such authorization for release when appropriate.
- My access to all University electronic information systems is subject to monitoring and audits in accordance with University policy.
- My User ID(s) constitutes my signature and I will be responsible for all entries made under my User ID(s). I agree to always log off of shared workstations.
- It is my responsibility to follow safe computing guidelines.
    - I will use **encrypted** computing devices (whether personal or UCSF-owned), such as desktop computers, laptop computers, tablets, mobile phones, flash drives, and external storage, **for any UCSF work purpose** which involves the use, exchange, or review of Protected Health Information or Personally Identifiable Information, including but not limited to, clinical care, quality reviews, research, educational presentations/conferences, and financial or personnel-related records. Encryption must be a UCSF-approved solution.
    - **I may be personally responsible** for any breach of confidentiality resulting from an unauthorized access to data on an unencrypted device due to theft, loss or any other compromise. I will contact the UCSF IT Service Desk at (415) 514-4100 for questions about encrypting my computing device.
    - I will not share my **Login or User ID and/or password** with any other person. If I believe someone else has used my Login or User ID and/or password, I will immediately report the use to the UCSF IT Service Desk at (415) 514-4100 and request a new password.
- Under state and federal laws and regulations governing a patient's right to privacy, unlawful or unauthorized access to or use or disclosure of patients' confidential information may subject me to disciplinary action up to and including immediate termination from my employment/professional relationship with UCSF, civil fines for which **I may be personally responsible**, as well as criminal sanctions.

By signing below:

- **I attest that I have encrypted or will encrypt all of my personal computing devices before using them for any UCSF work purpose. I will not use an unencrypted computing device for UCSF work purposes.**
- **I have read, understand, and acknowledge all of the above STATEMENTS OF UNIVERSITY PRIVACY POLICY and the ACKNOWLEDGEMENT OF RESPONSIBILITY.**

_____ Signature	_____ Date
_____ Print Name	_____ UCSF Department
_____ UCSF Employee Number	_____ Signature of Manager or UCSF Representative
❑ Non-UCSF Employee	_____ Print Manager or UCSF Representative Name

BADGE REQUEST

First Name: _____

Middle Name: _____

Last Name: _____

Title & Degree: _____

Social Security Number: _____

Date of Birth: _____

Birth City, State, Country: _____

Externship Dates From: _____ To: _____

Perimeter Access: NONE

****

FOR OFFICE USE ONLY

Badge Charge:

DEPT ID	FUND	PROJECT	FLEX FIELD	FUNCTION	SPEED TYPE
301008	5011	1111111	PEDOD	46	DOF08PEDOD

Entered date: _____ Employee ID # _____

Once entered, applicant can go to the Police Department with valid identification to have picture taken and pick up badge at:

Millberry Union, 500 Parnassus Ave, Rm. P-7
Monday through Friday - 7:15 a.m. to 5:30 p.m.
Tel: 415/476-2088

Student
Health & Counseling
A Division of Student Academic Affairs

Immunization Form 2013-14

Please complete and return to Student Health and Counseling Services

First Name _____ Middle Name _____ Last Name _____

Date of Birth _____ Phone # _____ Email address _____ School/Program _____ Gender _____

Immunization/TB Screening Categories	Required Data Submitted via the Online Immunization Portal (SAA Student Portal)
Measles (Rubeola) **NOTE:** A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid.	**Positive Measles IgG Antibody titer (required)** Titer Date _____/_____/_____ (positive titer only meets requirement) **Measles or MMR Immunizations** Dose 1 date: _____/_____/_____ ☐ Measles or ☐ MMR (select one) Dose 2 date: _____/_____/_____ ☐ Measles or ☐ MMR (select one) • If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer still negative, receive second dose of vaccine and repeat titer. If titer is still negative, contact Student Health. • Vaccine doses must be at least 28 days apart.
Mumps **NOTE:** A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid.	**Positive Mumps IgG Antibody titer (required)** Titer Date _____/_____/_____ (positive titer only meets requirement) **Mumps or MMR Immunizations** Dose 1 date: _____/_____/_____ ☐ Measles or ☐ MMR (select one) Dose 2 date: _____/_____/_____ ☐ Measles or ☐ MMR (select one) • If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer still negative, receive second dose of vaccine and repeat titer. If titer is still negative, contact Student Health. • Vaccine doses must be at least 28 days apart.
Rubella **NOTE:** A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid.	**Positive Rubella IgG Antibody titer (required)** Titer Date _____/_____/_____ (positive titer only meets requirement) **Rubella or MMR Immunizations** Dose 1 date: _____/_____/_____ ☐ Measles or ☐ MMR (select one) • Strongly Recommended: dates of a previous dose of vaccine (rubella or MMR) • If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer is still negative, contact Student Health.

Student Name: _____

Varicella (chicken pox) **NOTE:** A **PPD skin test** must be placed the SAME day as a **live virus vaccine** OR at least 30 days after the administration of a live virus vaccine to be considered valid.	**Positive Varicella IgG Antibody titer (required)** Titer Date _____/_____/_____ (positive titer only meets requirement) **Varicella Immunizations** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Please check titer first before receiving vaccine • Strongly Recommended: dates of two previous doses of vaccine (varicella) • If you have a negative or indeterminate titer, obtain one dose of vaccine and repeat titer. If titer still negative, receive second dose of vaccine and repeat titer. If titer is still negative, contact Student Health. • Vaccine doses must be at least 28 days apart.
Tdap (tetanus, diphtheria, pertussis)	**Tdap vaccine (required)** Dose 1 date: _____/_____/_____ • Vaccine must be Tdap, not Td. • Tdap is required regardless of date of last Td shot.
Hepatitis B Items **A, B, or C** on right will meet requirements.	A. **At least 2 of 3 doses** of Hepatitis B vaccine required (**all 3 doses** required if you have time to complete series), provide all three dates if series complete, **AND** **Positive Hepatitis B surface antibody** (required if you have completed the Hep B series) **Hepatitis B Immunizations** Dose 1 date: _____/_____/_____ Dose 2 date: _____/_____/_____ Dose 3 date: _____/_____/_____ **Hepatitis B Surface Antibody titer (required if series above complete)** Titer Date _____/_____/_____ (positive titer only meets requirement) **OR** B. **History of Hep B infection**: **Core antibody & surface antigen titer results** (these titers submitted in instance of prior infection). Only positive titers reflect history of past disease. If these titers are negative you should be immunized and receive the surface antibody titer. **Hepatitis B Core Antibody titer** Titer Date _____/_____/_____ (positive titer only meets requirement) **Hepatitis B Surface Antigen titer** Titer Date _____/_____/_____ (positive titer only meets requirement) **OR** C. **Received vaccination and titer didn't convert to positive**: If you have completed the Hep B series of 3 immunizations and your titer doesn't convert to reactive/positive, you must obtain and submit the date for a 4th dose of Hep B. Also submit the date of the previous three immunizations and negative/non-reactive titer. If you have already received two full course of Hep B vaccination (6 doses – 2 series of 3 shots – submit the dates of ALL doses of vaccine and negative titer).

Student Name: _____

Hepatitis B (cont'd)

Items **A, B, or C** on right will meet requirements.

Hepatitis B Immunizations

Dose 1 date: _____/_____/_____

Dose 2 date: _____/_____/_____

Dose 3 date: _____/_____/_____

Dose 4 date: _____/_____/_____

Dose 5 date: _____/_____/_____

Dose 6 date: _____/_____/_____

Hepatitis B Surface Antibody titer (required if series above complete)

Titer Date _____/_____/_____ (☐ positive titer ☐ negative titer)

Notes:
The Hepatitis B vaccination series requires 3 vaccinations given at minimum intervals of 0, 30 and 240 days (0, 1, and 6 months). Greater intervals are permissible. Do not restart a vaccination series; just pick up where you left off.

Following the completion of the series, and at least 4 weeks after the last dose, a Hepatitis B *Surface Antibody* titer must be drawn to confirm immunity.

TB Screening

- Please complete the 'Negative TB Screen' section if you have a history of negative TB screening (skin test, QF, TSpot)
- Please complete the '*Positive TB* Screen' section if you have a history of positive TB screening (skin test, QF, TSPot)

Negative TB Screen

(Please submit data for either **A, B, or C**. *Any* of the options will meet the requirement.)

NOTE: A **PPD skin test** must be placed the SAME day as a live virus vaccine OR at least 28 days after the administration of a live virus vaccine to be considered valid. Live virus vaccines include measles, mumps, rubella, and varicella.

A. PPD Skin Test performed by either method below:

Two-step PPD skin testing: Two PPD (tuberculosis skin testing) skin tests administered 7-31 days apart in the three months preceding entry into school, (Note: Do not have a TB skin test placed for 28 days following a live virus vaccine – must be placed same day as the live virus).

Kaiser Permanente patients may have a slightly altered PPD skin test pattern. Kaiser requests that patient have a PPD skin test placed, come back 7 days later for a read and have the second skin test placed on that same day.

or

History of regular skin testing: Documentation of a TB skin test completed within the three months prior to starting school and documentation of an additional skin test completed within one year of the more recent test.

PPD Test 1 Placement_____/_____/____ **Reading**____/_____/____ **reading** _____ **mm**

PPD Test 2 Placement_____/_____/____ **Reading**____/_____/____ **reading** _____ **mm**

OR

B. QuantiFERON testing: Documentation of a negative QuantiFERON Gold test reported within three months of entering school, (positive test, see below)

Test Date _____/_____/_____ **(only a negative test meets requirement)**

OR

C. T-SPOT testing: Documentation of a negative T-SPOT.TB test reported within three months of entering school, (positive test, see below)

Test Date _____/_____/_____ **(only a negative test meets requirement)**

Positive TB Screen

(Please submit data for **D, E, and F**. *All* data must be submitted to meet the requirement.)

D. POSITIVE skin test (reading > 10 mm) or POSITIVE QuantiFERON or POSITIVE T-SPOT:

PPD Read Date_____/_____/____ **reading** _____ **mm**

OR

Student Name: _____

Positive TB Screen (Cont'd)

(Please submit data for **D, E, and F**. All data must be submitted to meet the requirement.)

QuantiFERON testing: Documentation of a positive QuantiFERON Gold test reported within three months of entering school.

Test Date _____/_____/_____

OR

T-SPOT testing: Documentation of a positive T-SPOT.TB test reported within three months of entering school.

Test Date _____/_____/_____

AND

E. Chest X-ray

- Chest x-ray report: required

  x-ray results: ☐ normal ☐ abnormal

  Date: _____/_____/_____

Note: Date of chest x-ray report must be within 3 months of entering UCSF if INH Therapy has been taken for less than 6 months. If 6 months of INH therapy taken, chest xray report can be from time of positive screen.

AND

F. INH therapy taken:

☐ yes ☐ no

Date started: _____/_____/_____ Date ended: _____/_____/_____

length of treatment _____ months

Question about BCG? Students born outside the U.S. who received BCG vaccine should follow the TB screening requirements as listed above. If you have had slight reactions to a PPD skin test in the past, it is recommended you opt for QuantiFERON or T-Spot testing. For more information on BCG, please refer to the BCG handout in the packet.

TB Screening Questions **REQUIRED**

Have you ever received BCG?	❑ yes ❑ no **if yes:** Year _____ Country _____
	Country of Birth _____
Have you traveled and/or lived overseas in the past year?	❑ yes ❑ no **if yes:** Countries _____
	Last Return Date _____
Have you worked in a prison or homeless shelter in the past year?	❑ yes ❑ no
Have you entered a TB isolation room in the past year?	❑ yes ❑ no
Have you had exposure to a known case of TB in the past year?	❑ yes ❑ no
In the past six months have you experienced any of the following for greater than three weeks?	
Excessive sweating at night	❑ yes ❑ no
Excessive weight loss	❑ yes ❑ no
Persistent coughing	❑ yes ❑ no
Excessive Fatigue	❑ yes ❑ no
Coughing up blood	❑ yes ❑ no
Hoarseness	❑ yes ❑ no
Persistent fever	❑ yes ❑ no

I attest that all dates and immunizations listed on this form are correct and accurate.

Provider's Signature _____ Date _____
Physician, Nurse Practitioner, Physician's Assistant, or RN

Provider's name printed_____Phone number _____
Physician, Nurse Practitioner, Physician's Assistant, or RN

Clinic Stamp – If the verifying provider's office has clinic stamp, please place here.