# Pharmacy Student Checklist

**STUDENT NAME:** _________________________  **PHONE** _______________________________

**SCHOOL NAME:** _________________________  **EMAIL ADDRESS** _________________________

**Rotation Location/Department**

<table>
<thead>
<tr>
<th>Student Initial</th>
<th>Requirements</th>
<th>Education Staff Note/Initial</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agreement validated through Educational Services</td>
<td></td>
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<tr>
<td></td>
<td>Validated professional liability insurance</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>I have completed the Application form and submitted to the Education Department.</td>
<td></td>
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<tr>
<td></td>
<td>I have read the St. Luke’s Confidentiality Policy and Mission Statement and signed the Confidentiality Agreement for Students.</td>
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<td></td>
<td>I have completed St. Luke’s orientation.</td>
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<tr>
<td></td>
<td>I have completed the Dashboard and received my password.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Completed St. Luke’s Vehicle Registration form and arranged to get a Student Parking Permit</td>
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<tr>
<td></td>
<td>Obtained a photo ID from St. Luke’s that identifies me as a student. (Security person verification)</td>
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<tr>
<td></td>
<td>I will dress professionally and wear a nametag at all times while I am at St. Luke’s Regional Medical Center.</td>
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<tr>
<td></td>
<td>20% discount on meals at St. Luke’s cafeteria</td>
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<td></td>
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<tr>
<td></td>
<td>Will return process evaluation to Debra Servatius, Education Department before last day of rotation.</td>
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</tbody>
</table>
Name in Full _________________________________________________________________

Permanent Address  __________ ____________________________________________________________________________________

Phone Number ________________________________________________________________

Local Address  ________________________________________________________________

Local Phone Number ____________________________________________________________

Preceptor ______________________________________________________________________

Year and Month of Expected Graduation  _________________________________________

Name of School  ______________________________________________________________________

Rotation Location/Department ______________________________________________________

From  __________________________________     To ________________________________

(Month/Day/Year)  (Month/Day/Year)

Total of Education Hours __________________

REQUIREMENTS – IMMUNIZATIONS:

- Tuberculosis testing current within one year.
- Rubella/Rubeola – Individuals born before 1957 are considered immune. Individuals born after 1957 must be able to demonstrate documented immunity to Rubella/Rubeola by lab result or verification of 2 MMR vaccines. Individuals with history of vaccination without documentation should receive 1 MMR vaccine, individuals with no history or documentation of vaccination should receive 2 MMR vaccines, 1 month apart. If student believes she is pregnant, serology may be done to check immunity.
- Hepatitis B vaccination or statement of declination as per OSHA standards.
- Chicken Pox – I have had a history of Chicken Pox or I have attached a titer demonstrating immunity.

* Attach Immunization Schedule

- Call Education Department as soon as possible at (208) 381-1503 to schedule an appointment for student orientation. This must be completed prior to the start of your clinical rotation.
- Bring photo ID and completed forms to St. Luke’s orientation.

I hereby certify that the information I submit in this Application is complete and correct to the best of my knowledge and belief.

___________________________________________________________________________

Pharmacy Student ____________________ Date ________________
Confidentiality Agreement for Students and Instructors

I am a student or instructor at St. Luke’s Regional Medical Center, Ltd. (“St. Luke’s”). I understand that any information I may obtain during the course of my experience regarding patients, employee health information and financial data, strategic planning initiatives or electronic data must be kept in the strictest of confidence. I will carry out my assignments and duties at St. Luke’s in a highly ethical and professional manner.

I have been given a copy of the Summary of St. Luke’s Privacy Policies as Required by HIPAA and agree to abide by the terms set out in those policies. I realize that failure to adhere to these policies may result in the restriction or revocation of my authorization for observation at St. Luke’s during my affiliation with St. Luke’s.

I understand that the mission of St. Luke’s is to improve the health of our regional community, and the values of St. Luke’s are safety, trust and respect, teamwork, partnership and service, compassion, integrity, financial efficiency and responsibility.

I agree that I will not disclose any confidential information gained during my clinical experience at St. Luke's, and that I will conduct myself in an ethical and professional manner at all times. Failure to adhere to these expectations of conduct may result in, but not limited to, counseling and/or denial of access to observational opportunities at St. Luke’s.

________________________________________  __________________________
Signature                                        Address

________________________________________  __________________________
Printed Name                                     City, State  Zip

________________________________________  __________________________
Birth Date (month/date)                           Phone Number

☐ Please check this box if you do not want to receive informational materials from St. Luke’s Regional Medical Center.
POLICY TITLE: Confidentiality of Information, Ethical Conduct, Mission and Values of Individuals Associating with St. Luke’s Health System or any of its related Facilities

POLICY STATEMENT: Maintaining strictest confidentiality of sensitive information, whether it be patient records personnel files, financial data, planning strategies, peer review data or computer database files, is an ethical imperative of every individual associated with St. Luke’s Regional Medical Center. Every employee, contract employee, volunteer, medical staff member, student, instructor or external/data reviewer shall be expected to observe strict confidentiality of such information for the protection of patient rights, individual rights and organizational integrity. (See also Related Policies on Page 3).

Consequences Of Non-Compliance:

Failure to maintain confidentiality of information and/or failure to comply with this policy may result in, but not necessarily be limited to the following:

- Corrective action and/or termination of employment
- Counseling and/or dismissal from volunteer membership
- Dismissal from committee assignments
- Review of Medical Staff membership status
- Denial of access to sensitive information resources
ST. LUKE’S STUDENT VEHICLE REGISTRATION FORM

- PLEASE PRINT -

**Student / Vehicle Information**

School Name (Print) ____________________________________________________________

Department Name (Print) ______________________________________________________

Student First Name (Print) ____________________________________________________

Student Last Name (Print) ____________________________________________________

Vehicle License Plate (Print) _________________________________________________

State Vehicle is registered in (Print) ___________________________________________

Vehicle Make (Print) _________________________________________________________

Vehicle Model (Print) _________________________________________________________

Vehicle Color (Print) _________________________________________________________

**Clinical Schedule at St. Luke’s:**

Date: ___________________________ through _____________________________

Times:

- Monday: ____________________ to ____________________
- Tuesday: ____________________ to ____________________
- Wednesday: ____________________ to ____________________
- Thursday: ____________________ to ____________________
- Friday: ____________________ to ____________________
- Saturday: ____________________ to ____________________

**Parking Policy, Instructions and Locations:**

1. Students attending St. Luke’s Boise campus **must** park in the Warm Springs Employee parking lot. (Corner of Warm Springs and Broadway Avenue).

2. Any Students found parking in the Patient / Visitor parking lot will be towed without notice at the owner’s expense at a minimum charge of $130.00.

The St. Luke’s student parking permit provided by your instructor must be displayed on the dashboard of your vehicle when parked on St. Luke’s Property. Any student vehicle found not in compliance with this policy will be towed at owner’s expense.

Student Signature ____________________________________________________________
STUDENT PHOTO ID VERIFICATION

A photo identification was presented to St. Luke’s Security upon issuing a temporary St. Luke’s Student Identification badge to ________________________________

Student Name

for the time period beginning ________________________________ and expiring on ________________________________.

Expiration Date

__________________________________________

Signature of Security Department Personnel

Date

Copy: St. Luke’s Education Department
Attn: Debra Servatius
ST. LUKE'S REGIONAL MEDICAL CENTER  
Boise, Idaho  

STUDENT EDUCATIONAL EXPERIENCE EVALUATION  
Date: _____________________

<table>
<thead>
<tr>
<th>Strong Agree-1</th>
<th>Agree-2</th>
<th>Undecided -3</th>
<th>Disagree-4</th>
<th>Strong Disagree-5</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA</td>
<td>A</td>
<td>U</td>
<td>D</td>
<td>SD</td>
</tr>
</tbody>
</table>

1. My orientation to St. Luke’s was informative and helpful.  
   1 2 3 4 5

2. I was well received by St. Luke’s staff during my rotation.  
   1 2 3 4 5

3. I feel more confident in dealing with patients.  
   1 2 3 4 5

4. St. Luke’s environment was conducive to meeting my goals.  
   1 2 3 4 5

5. This rotation was helpful to my professional development.  
   1 2 3 4 5

6. I was able to access the information I needed to provide quality patient care.  
   1 2 3 4 5

7. The length of the rotation was adequate.  
   1 2 3 4 5

8. I received sufficient attention and support from my supervising pharmacist.  
   1 2 3 4 5

9. I received sufficient attention and support from St. Luke’s staff.  
   1 2 3 4 5

10. As a result of my rotation here I would identify St. Luke’s as an Employer of Choice.  
    1 2 3 4 5

List activities by your supervising pharmacist that enhanced your learning:

Give two suggestions that would enhance your learning here at St. Luke’s:

Please return your evaluation to Debra Servatius - Education Department