Employee Student Placement Attestation form

PALOMAR HEALTH

Welcome!

Thank you for choosing Palomar Health to complete your clinical rotation. This form is required to be filled out by employees seeking student placements at Palomar Health.

Please fill in the information below and e-mail the completed form to the appropriate education coordinator at Palomar health no later than 5 days from receiving this form.

Attestation of Requirements

____ I understand that Palomar Health must have an executed Education Affiliation Agreement with my Academic Institution.

____ I understand that I will complete my student-related activities on a unit/department for which I am not scheduled to work in throughout the duration of my student experience.

____ I understand that I am responsible for finding my own preceptor, who I do not work with on a regular basis, and is not a part of my chain of command.

____ I understand that I will not be compensated while completing student-related activities.

____ I will not work on any student-related activities during my scheduled working hours. I will also not conduct any work-related responsibilities while serving in a student capacity.

____ I will adhere to dress code standards set forth by my academic institution including student badge identification and will not wear my employee badge while serving in a student capacity. The opposite holds true when working in an employee capacity.

____ In consideration of the permission granted by Palomar Health for this experience, I waive all claims for damage or loss to my person or property which may be caused by any act or failure to act by Palomar Health, its officers, agents or employees. I assume the risk of all situations or occurrences that may be encountered during this student experience.

____ I understand that Palomar Health has the right to revoke my student access if any of the above requirements are not followed.

Nursing Students

____ I understand that my student request must be submitted by my Academic Institution to the San Diego Consortium for processing by the Academic Coordinator at Palomar Health.

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PALOMAR HEALTH

STUDENT CONTACT INFORMATION		
YOUR NAME	EMPLOYEE ID#	TODAY'S DATE
PHONE	EMAIL	
UNIT MANAGER NAME	HOME UNIT	

SCHOOL INFORMATION	
SCHOOL NAME	PROGRAM
CONTACT/COORDINATOR NAME	CONTACT/COORDINATOR TITLE
PHONE	EMAIL

PRECEPTOR INFORMATION (If Applicable)		
PRECEPTOR NAME	TITLE	
DEPARTMENT	FACILITY -SELECT FACILITY-	
START DATE	END DATE	TOTAL HOURS

Agreement: I understand that signing this form constitutes a legal signature confirming that I acknowledge and warrant the truthfulness of the information provided in this document.

PH EMPLOYEE/STUDENT NAME	DATE
UNIT MANAGER NAME	DATE
PRECEPTOR NAME	DATE

Submitting the Form

Send your completed form and email your leader (manager and above) and copy Academics@PalomarHealth.org for approval.

For Office Use Only

Consortium Request #