ZUCKERBERG
SAN FRANCISCO GENERAL
Hospital and Trauma Center

DEPARTMENT OF EDUCATION & TRAINING
DET
CURRIN-CARLISLE LEARNING CENTER

Student Placement Form

Please have your demographic information, professional license number, academic programs information, school's contact information, immunization records, and preceptor contact information prior to complete this form.

Name *

First Name Last Name

Date *

Month – Day – Year

Gender *

Date of Birth (MM/DD/YY) *

Phone Number *

Area Code – Phone Number

Address *

Street Address

City

Please Select

State

Zip Code

Student's School Email

example@example.com

1. Do you have a Professional License number? *

- [ ] Yes
- [ ] No

If yes, please type "attached" and provide a copy of Professional License

2. Have you been placed at ZSFG as a student before? *

- [ ] Yes
- [ ] No

If yes, please indicate the Date and Department

Education

Only include applicable degree for student placement experience

School Name *

School Address *

City

State

Area of Study/Practice *

Type of Degree *

1. Approved School *

- [ ] Yes
- [ ] No

2. Approved Program *

- [ ] Yes
- [ ] No

3. Start Date *

Month – Day – Year

End Date *

Month – Day – Year

4. Evaluation for Student Required: *

5. Hours/Time Required: *

If yes, what is the requirement (hrs./wks)

6. Course Title: *

7. Total # of Credits/Units:

School's Contact Information

8.School Contact Name: *

First Name Last Name

Title: *

School Contact Email: *

Phone Number: *

Area Code – Phone Number

9. Internship Objectives attached *

- [ ] Yes
- [ ] No
- [ ] n/a

10. Student contract attached *

- [ ] Yes
- [ ] No
- [ ] n/a

Precepting Department/Unit

1. Department/Unit *

2. Student Schedule/Shift *

3.Department specific Students Responsibilities *

4. Preceptor Name *

5. Preceptor E-mail (example@example.com) *

6. Preceptor Phone Number *

Health Requirements

Students are required to provide proof of immunizations, screening and/or titers of below BEFORE starting placement. Although not required, we strongly recommend Hepatitis B screening and vaccination. For clinical students, health screening is required at the beginning of every clinical rotation. Complete below and show proof to the preceptor/ZSFG STAFF when requested. Actual records are not needed; do not attach.

Vaccination Attestation

If you indicate "No" on any of the below questions, please contact your preceptor to proceed further.

Rubella (German Measules): Vaccinated or Titers showing Immunity

- ☐ Yes
- ☐ No
- ☐ Other

Rubeola (Measules): Vaccinated or Titers showing Immunity

- ☐ Yes
- ☐ No
- ☐ Other

Varicella: Vaccinated or Titers showing Immunity

- ☐ Yes
- ☐ No
- ☐ Other

Mumps: Vaccinated or Titers showing Immunity

- ☐ Yes
- ☐ No
- ☐ Other

Seasonal Flu (Flu season only)

- [ ] Yes
- [ ] No
- [ ] Other

Tuberculosis: PPD negative/chest x-ray negative (within 1 yr. & 3 months of projected start date, two tests total)

- [ ] Yes
- [ ] No
- [ ] Other

Covid19 Vaccine (1st, 2nd and booster dose)

- [ ] Yes
- [ ] No
- [ ] Other

Emergency Contact

Please provide a contact person in case of an emergency while on the ZSFG campus or affiliated campus

Name *

First Name

Last Name

Relationship *

Phone Number 1 *

Phone Number 2

Oath of Confidentiality

As a condition of clinical placement, conducting research, a student internship or the observation of patient care at Zuckerberg San Francisco Hospital and Trauma Center, I

agree not to divulge any information obtained in the course of such training or research to unauthorized persons, and not to public or otherwise make public any information regarding persons who have received resources such that the person who received services is identifiable. I further agree not to divulge or public general patient information or statistics without prior authorization from my preceptor or hospital administration. I further agree to hold in strict confidentiality on all matters discussed on Medical Staff or hospital committee meetings to which I might be privy. I recognize that the unauthorized release of confidential information may make me subject to civil action under provisions of the Welfare and Institutions Codes.

Signature *

Date *

Month – Day – Year

ZSFG COVID-19 Standards for Students, Instructors, and Faculty

I have read the ZSFG COVID-19 Standards for Students, Instructors, and Faculty and attest to the provided standards in **https://wp.me/a8NdYm-1mC**

- ☐ Yes
- ☐ No

Orientation

ZSFG Online Orientation Completed

- ☐ Yes
- ☐ No

Preceptor Name *

First Name Last Name

Date *

Month – Day – Year

Dept/Unit *

Preceptor Signature

Please provide a wet signature in the box ----->

GSDGSD

Student Declaration

I certify that the information provided on this form is true, accurate and complete. I agree to provide the immunization/screening records upon the hospital's request. I understand that any false information will cause my disqualification in any programs on the Zuckerberg San Francisco General Hospital (ZSFG) campus and affiliated clinics. I recognize that all confidential information obtained or observed at ZSFG is in confidential nature. I agree, that at all times, to ensure the confidentially of all sensitive information I have contact with, comply with applicable laws and maintain patient privacy. I understand that failure to comply with any of the above requirements may result in cancellation of my instruction agreement. I further attest that I have received appropriate written material and introduced to the hospital and the appropriate department/unit/clinic protocol and standards.

Date *

Month – Day – Year

Student Signature *

Please provide a wet signature below

Submission

Please Print the completed form and submit directly to your assigned preceptor (ZSFG staff contact or department). If you have any questions regarding this form, please contact your ZSFG preceptor.