PRECEPTORSHIP / CLERKSHIP AGREEMENT

THIS AGREEMENT, made this date, ______________________ by and between

(student) ______________________ (university) ______________________

and **Peninsula Regional Medical Center** in patient care areas including these special areas: **(check all that apply)**

☐ Surgical Services ☐ Emergency Services Dept. ☐ Pediatrics

☐ Mother / Baby ☐ Labor and Delivery ☐ NICU (Special Care Nursery)

☐ PRMC Satellite Office: Location ______________________

Referring Agency / School: ______________________

Program Enrolled In: ______________________

Student Name: ______________________

Preceptor Name **and** Credentials: ______________________

Student Home Address: ______________________

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Student Telephone: ______________________

Student Email Address: ______________________

Is Provider Requesting Computer Access for Student? ____ Yes ____ No

WHEREAS, the Referring Agency has requested that Peninsula Regional Medical Center permit the student to participate in a preceptorship / clerkship agreement at Peninsula Regional; and

WHEREAS, the student desires to participate, and Peninsula Regional Medical Center is agreeable to such proposal subject to the terms and conditions of this Agreement;

NOW, THEREFORE, THE PARTIES HERETO DO HEREBY AGREE AS FOLLOWS:

1. The student shall participate in a "preceptorship / clerkship program" as set forth above during the period of ______________ to ______________
2. During the term of this Agreement, the Referring Agency shall:
   (a) Be solely responsible for compensation of the student.
   (b) Students and Faculty of the program shall be required to carry liability insurance having policy limits in the minimum of $1,000,000 per incident and $3,000,000 aggregate, protecting same against all liability arising out of the acts of omission of the student during the course of the program.
3. The student agrees to abide by all the rules and regulations of Peninsula Regional Medical Center during the course of this Agreement including without limitation, protection of the privacy of Peninsula Regional Medical Center's patients.
4. The contract between the educational institution of the precepting student and Peninsula Regional Medical Center, shall be incorporated in its entirety to this preceptorship agreement.

SIGNATURES: The precepting student is responsible for acquiring the signatures of the educational institution, the preceptor, and the supervising physician, when a preceptor is an Advanced Practice Provider, i.e. Physician Assistant, Nurse Practitioner, Certified Registered Nurse Anesthetist or Certified Nurse-Midwife and the Perioperative Educator (where applicable).

____

Precepting Student Signature Date

____

Student's Educational Institution Signature Date

____

Preceptor (Print Name)

____

Preceptor Signature Date

____

Supervising Physician (Print Name)

Required when Preceptor is an Advanced Practice Provider, i.e. Physician Assistant, Nurse Practitioner, Nurse Anesthetist or Nurse Mid-wife

____

Supervising Physician Signature Date

Required when Preceptor is an Advanced Practice Provider, i.e., Physician Assistant, Nurse Practitioner, Nurse Anesthetist or Nurse Mid-wife

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VP, Medical Affairs, PRMC Date

____

Perioperative Educator, PRMC Date

PENINSULA REGIONAL MEDICAL CENTER

AUTHORIZATION AND RELEASE STATEMENT APPLICATION FOR PRECEPTORSHIP

By my signature to this Authorization and Release Statement, I acknowledge the following where applicable:

I have received the written explanation of the process. I agree to be bound by the terms thereof.

I authorize Peninsula Regional Medical Center to consult with members of professional and administrative staff of other facilities, healthcare and/or educational, with which I have been associated, with any law enforcement agencies, and with others who may have information regarding my competence, character and material to an evaluation of my clinical competence.

A PHOTOSTAT OR OTHER REPRODUCTION OF THIS STATEMENT SHALL BE CONSIDERED VALID

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Student Signature Date