

2019–2020
Medical Scribe
Program Handbook

Table of Contents

Absences, Excused	5
Academic Review Procedure	27-28
Admissions Criteria and Procedures	4
Advising, Role of the Student in	5
Background Checks, Criminal and Abuse	9
Cardiopulmonary Resuscitation	6
Clinical Participation Requirements	19
Completed Records	8
Confidentiality Agreement Form	21-22
Dress Code	6
Grading; Graduation	7
Health Evaluation Guidelines	8
Hepatitis B Documentation.....	8
Hepatitis B Consent/Decline Forms	15-17
Iowa Core Performance Standards	11-12
Mandatory Reporter Training	6
Program of Study	10
Requirements for the Medical Scribe Program	6
Signature Sheet of Understanding	31
Social Media Policy	25
Statement of Knowledge of the Policy and Protocol for Occupational Exposure to Bloodborne Pathogens	23
Student Appeal Process Form.....	29
Student Insurance Overview	5
Tuberculosis Test	8
Vaccinations	8
WITCC Clinical Health Evaluation Form	13-14

Students are encouraged to read the WITCC general catalog for information regarding student rights, services, activities, and special programs which may be available to them. A copy of the catalog is available by calling Enrollment Services, WITCC, 712-274-8733, Ext. 1325 or 800-352-4649 or on our Website at www.witcc.edu.

Admissions Criteria and Procedure

Medical Scribe Program

Sioux City

Specific Admission Requirements:

- **All students** must submit a copy of their high school transcript (or equivalency diploma-GED) and all college transcripts to the Admissions Office for evaluation.

General admission procedures for all WITCC students is available in the WITCC College Catalog.

All students must meet the following criteria for admission/acceptance into the medical assistant program:

- Verification of High School, GED or HSED Graduation

All students must meet one of the following criteria for admission/acceptance into the medical assistant program:

CRITERIA 1 FOR ACCEPTANCE

1. Submitted documentation of composite ACT score of at least 19

OR CRITERIA 2 FOR ACCEPTANCE

1. Associate Degree or higher from an accredited program.

OR CRITERIA 3 FOR ACCEPTANCE

1. Verification of high school official transcript of GPA 2.0 or higher AND
2. Completion of (1) year high school science equivalent with no grade lower than a C.

OR CRITERIA 4 FOR ACCEPTANCE

1. Completion of BIO 163 and HSC 114 with no grade lower than a C

Student Insurance Overview

Malpractice Insurance – Students are highly encouraged to obtain their own individual coverage.

Student Accident and Health Insurance – From the Student Handbook: “WITCC does not have a compulsory insurance plan, but the College recommends that students enroll in a voluntary group accident and/or health insurance plan available through commercial insurance companies.” Insurance information is made available to students attending orientation sessions and is available in Enrollment Services. College liability insurance is not a substitute for health or accident insurance. **It is highly recommended that students obtain their own health insurance coverage.**

Excused Absences

Military duty, jury duty, or if you are subpoenaed are considered excused absences.

Academic Advising

Academic advising assists students in realizing the maximum educational benefits available by helping them to better understand themselves and to learn to use the resources available at WITCC to meet their specific educational needs.

Role of Student in Advising

The student is to contact his or her advisor regarding all academic issues. It is necessary to make advance appointments with advisors for efficiency in scheduling. Faculty is available to meet new students taking either support courses or Medical Scribe courses prior to registering.

Faculty is available at the Sioux City Campus for advising and program inquiries. Contact your advisor to schedule an appointment.

Advisor signatures are required on all course schedules, drop/add slips, transfer of program and credit forms, and forms for withdrawal from programs or the college.

The student is ultimately responsible to meet **all** requirements for graduation.

Requirements for the Medical Scribe Program

1. CPR/First Aid Certification – American Heart Association BLS Health Care Provider Course/First Aid
2. Child Abuse – Mandatory Reporter Training
3. Adult Abuse – Mandatory Reporter Training
4. Health Evaluations
5. Criminal and Abuse Background Checks

Photocopies of **CPR, First Aid, Child Abuse, and Adult Abuse certification** must be turned in to the instructor prior to the start of the externship. (Students are responsible for obtaining their own photocopies.) If these requirements are not completed, students **cannot** be allowed to participate in the externship.

Cardiopulmonary Resuscitation/First Aid

You are required to have a current CPR/First Aid card and must have completed the American Heart Association BLS Health Care Provider course. This course is specifically for health professionals. If you now hold a card and it is due to expire halfway through the year, you should renew it early so that your card is current during the total Medical Scribe clinical externship. For information on CPR/First Aid courses offered at WITCC, contact WITCC Registration at 712-274-6404 or 1-800-352-4649, Ext. 6404.

Child and Adult Abuse – Mandatory Reporter Training

All health personnel are mandatory reporters of child and adult abuse and are required to take a short course, approximately three hours in length, to provide information on the law, recognition, documentation and reporting of child and adult abuse. For information on the courses offered at WITCC, contact WITCC Registration at 712-274-6404 or 1-800-352-4649, Ext. 6404.

Health Evaluation

Completed health evaluation forms must be turned in a minimum of two weeks prior to the start of spring semester or last semester of study. Send completed health evaluation forms by e-mail to: Marilyn West, RN, BSN; Marilyn.west@witcc.edu

Clinical Dress Code

Students in the externship courses will be required to wear the following uniform while caring for patients.

1. Students are required to wear business professional clothing with a white lab coat. No blue jeans, capris, skorts or shorts.
2. Shoes must be clean, and be worn only for work/externship duties. No open toe shoes allowed.
3. Students must wear a WITCC name badge provided by the institution. If lost, a fee will be charged for replacement.
4. Hair must be clean, off the collar, pulled back, and secure when a student is on duty. Only natural hair colors will be allowed (i.e., no pink, green, orange, purple, etc.). Hair accessories must be white or the same color as the student's hair. Beards, mustaches, and sideburns need to be clean, well manicured, and closely trimmed to the face.
5. Fingernails must be clean, short, and neatly filed. No artificial nails. Colored nail polish is not permitted. If clear nail polish is worn, it must not be chipped. Makeup should be moderate.
6. A student may wear rings on no more than one finger. One pair of pierced earrings (one earring in each ear) is allowed in white, gold, or silver and no larger than ¼ inch in diameter or dangling. No bracelets or neck chains may be worn. No other visible facial piercing (i.e., brow, nose, tongue).
7. Visible tattoos must be covered.
8. Gum chewing, eating, and cell phones are not acceptable in clinical/lab areas.
9. Offensive body odor and bad breath will be dealt with by the clinical instructor on an individual basis. No perfume or cologne.
10. Students may not use tobacco products at any time during their work shifts. This includes meal periods and rest breaks, on or off campus. Clothing worn during clinical/labs must be free of the odor of tobacco.

Grading

The specific grading scale for all courses is determined by the course instructors. The grading scale, and requirements to achieve desired grades, will be explained at the beginning of each course.

Graduation

WITCC students must meet the graduation requirements as set forth in the general WITCC College Catalog and the WITCC Student Handbook. Students must achieve a final grade of “C” (2.0) or better in all support and core courses to be eligible for graduation.

Health Evaluation

To provide a safe and healthy environment for yourself and those you will come into contact with, you must complete a health evaluation **prior** to entering the clinical phase of your education. **If these requirements are not completed, you will not be allowed to participate in the clinical rotation.** Therefore, Western Iowa Tech Community College has contracted with Mercy Business Health Services to assist in evaluating the completion of this health evaluation.

Health Evaluation includes:

Health history, hearing, vision, immunization record, and physician physical.

You must complete the health evaluation and immunizations prior to enrollment in MAP-215 and your clinical rotation.

Current Vaccinations:

You must provide proof that your vaccination status is current. Dates must accompany the physical; just listing “current vaccinations” will not satisfy the requirements. If you are unsure of your vaccination status, you should have your immunizations updated.

Hepatitis B:

You must show documentation of either:

1. Receiving the Hepatitis B Vaccine (a series of three shots for the prevention of Hepatitis B, a disease of the liver);
2. Decline or Accept Form;
3. OR that you are currently receiving the series by providing a photocopy of the consent verifying the process.

If you are planning to start the vaccine at a later date, sign the Decline to Accept Form and submit it.

Tuberculosis Test:

Because of the increased incidence of tuberculosis, each student is required to have a current T.B. skin test. The T.B. skin test is valid for **one year**. Depending on site of externship, a second T.B. skin test may be required.

Completed Records:

The completed records will be reviewed. If there is need for additional information or tests, you will be contacted. **Please make a copy of your health evaluation for your own records. In the future, copies will not be made available for you.**

Please complete the health evaluation in its **entirety** and return promptly by email to Marilyn West, RN, BSN; Western Iowa Tech Community College; marilyn.west@witcc.edu. You may contact Marilyn at 712-274-8733, Ext. 1256, or marilyn.west@witcc.edu. **Your health evaluation is considered current for two years. If the course of your education extends past two years, your health evaluation must be repeated.**

Mercy Business Health Services is available if you should have questions, if you need help finding a physician, or if you would like us to provide you with vaccinations. You may contact Mercy Business Health Services at 274-4250.

Criminal Background - General Information

Pre-Clinical:

WITCC will complete criminal background checks on all health students. Based on the findings, a determination will be made if the student is eligible to participate in clinical activities. See program handbook for additional information.

Post-Graduation Exams:

Criminal charges/convictions, abuse charges (adult or child), or a substance abuse history may impact a graduate's ability to obtain registration or licensure in the graduate's profession. Each licensing board will make the determination if a criminal background check will be completed before the graduate is eligible to write licensing/registration exams. See program handbook for additional information.

Employment in Health Care Professions:

Employers have varied hiring policies based on their review of an applicant's criminal background history.

Graduates/students need to be aware that:

- * Clearance for clinical while a student
- * Graduation from the program
- * Successful passage of licensing or registration exams

does not guarantee graduates will be eligible for employment at some agencies. Employment eligibility is determined by the hiring policies at each health care agency.

Western Iowa Tech Community College

Program of Study

Medical Scribe Program

Semester I

Catalog Number	Course Title	Semester Hours
SDV-108	The College Experience	1
HSC-114	Medical Terminology	3
BIO-163	Essentials of Anatomy & Physiology	4
HIT 136	Scribe Fundamentals I	3
HIT 248	Essentials of Medical Coding	2
MAP 402	Medical Law and Ethics	2
CSC 110	Introduction to Computers	3
	Total First Semester	18

Semester II

Catalog Number	Course Title	Semester Hours
HSC 143	Pharmacology	3
HSC 218	Clinical Pathology for Allied Health	3
HIT 236	Scribe Fundamentals II	4
HIT 301	Electronic Health Records	3
MAP 134	Medical Transcription I	3
PSY 102	Human & Work Relations	3
	Total Second Semester	19
	Program Total Credits	37

IOWA CORE PERFORMANCE STANDARDS

Iowa Community colleges have developed the following Core Performance Standards for all applicants to Health Care Career Programs. These standards are based upon required abilities that are compatible with effective performance in health care careers. Applicants unable to meet the Core Performance Standards are responsible for discussing the possibility of reasonable accommodations with the designated institutional office. Before final admission into a health career program, applicants are responsible for providing medical and other documentation related to any disability and the appropriate accommodations needed to meet the Core Performance Standards. These materials must be submitted in accordance with the institution's ADA Policy.

CAPABILITY	STANDARD	SOME EXAMPLES OF NECESSARY ACTIVITIES (NOT ALL INCLUSIVE)
Cognitive-Perception	The ability to gather and interpret data and events, to think clearly and rationally, and to respond appropriately in routine and stressful situations.	<input type="checkbox"/> Identify changes in patient/client health status <input type="checkbox"/> Handle multiple priorities in stressful situations
Critical Thinking	Utilize critical thinking to analyze the problem and devise effective plans to address the problem.	<input type="checkbox"/> Identify cause-effect relationships in clinical situations <input type="checkbox"/> Develop plans of care as required
Interpersonal	Have interpersonal and collaborative abilities to interact appropriately with members of the healthcare team as well as individuals, families and groups. Demonstrate the ability to avoid barriers to positive interaction in relation to cultural and/or diversity differences.	<input type="checkbox"/> Establish rapport with patients/clients and members of the healthcare team <input type="checkbox"/> Demonstrate a high level of patience and respect <input type="checkbox"/> Respond to a variety of behaviors (anger, fear, hostility) in a calm manner <input type="checkbox"/> Nonjudgmental behavior
Communication	Utilize communication strategies in English to communicate health information accurately and with legal and regulatory guidelines, upholding the strictest standards of confidentiality.	<input type="checkbox"/> Read, understand, write and speak English competently <input type="checkbox"/> Communicate thoughts, ideas and action plans with clarity, using written, verbal and/or visual methods <input type="checkbox"/> Explain treatment procedures <input type="checkbox"/> Initiate health teaching <input type="checkbox"/> Document patient/client responses <input type="checkbox"/> Validate responses/messages with others
Technology Literacy	Demonstrate the ability to perform a variety of technological skills that are essential for providing safe patient care	<input type="checkbox"/> Retrieve and document patient information using a variety of methods <input type="checkbox"/> Employ communication technologies to coordinate confidential patient care

Reviewed and Approved April 2018

CAPABILITY	STANDARD	SOME EXAMPLES OF NECESSARY ACTIVITIES (NOT ALL INCLUSIVE)
Mobility	Ambulatory capability to sufficiently maintain a center of gravity when met with an opposing force as in lifting, supporting, and/or transferring a patient/client.	<input type="checkbox"/> The ability to propel wheelchairs, stretchers, etc. alone or with assistance as available
Motor Skills	Gross and fine motor abilities to provide safe and effective care and documentation	<input type="checkbox"/> Position patients/clients <input type="checkbox"/> Reach, manipulate, and operate equipment, instruments and supplies <input type="checkbox"/> Electronic documentation/keyboarding <input type="checkbox"/> Lift, carry, push and pull <input type="checkbox"/> Perform CPR
Hearing	Auditory ability to monitor and assess, or document health needs	<input type="checkbox"/> Hears monitor alarms, emergency signals, auscultatory sounds, cries for help
Visual	Visual ability sufficient for observations and assessment necessary in patient/client care, accurate color discrimination	<input type="checkbox"/> Observes patient/client responses <input type="checkbox"/> Discriminates color changes <input type="checkbox"/> Accurately reads measurement on patient client related equipment
Tactile	Tactile ability sufficient for physical assessment, inclusive of size, shape, temperature and texture	<input type="checkbox"/> Performs palpation <input type="checkbox"/> Performs functions of physical examination and/or those related to therapeutic intervention
Activity Tolerance	The ability to tolerate lengthy periods of physical activity	<input type="checkbox"/> Move quickly and/or continuously <input type="checkbox"/> Tolerate long periods of standing and/or sitting as required
Environmental	Ability to tolerate environmental stressors	<input type="checkbox"/> Adapt to rotating shifts <input type="checkbox"/> Work with chemicals and detergents <input type="checkbox"/> Tolerate exposure to fumes and odors <input type="checkbox"/> Work in areas that are close and crowded <input type="checkbox"/> Work in areas of potential physical violence <input type="checkbox"/> Work with patients with communicable diseases or conditions

Reviewed and Approved April 2018

WITCC Clinical Health Evaluation



(PLEASE PRINT)

Last Name _____ First Name _____ Middle Initial _____

Date of Birth: _____ E-mail: _____ Program of Study: _____

Do you have any known allergies? Yes No If yes, list all known allergies: _____

Student Signature: _____ Date: _____

Health Care Provider Complete The Following

Immunizations:

MMR #1:		MMR #2:		
Measles titre results:		Mumps titre results:		Rubella titre results:
Tetanus/Diphtheria (valid if within 10 years)			Date Given:	
Hepatitis B #1:	#2:	#3:	Hepatitis B titre results:	
Chickenpox #1:	#2:	Chickenpox titre results:		

** Titre results must include numerical value – not just “positive, negative, immune”.

#1 Tuberculin Skin Test-Mantoux 5 TU/PPD (valid if within one year) Given: _____ Read: _____
PPD result (state reaction in mm): _____ Professional Signature: _____

#2 Tuberculin Skin Test-Mantoux 5 TU/PPD (valid if within one year) Given: _____ Read: _____
PPD result (state reaction in mm): _____ Professional Signature _____

Questions:

#1 - Have recommendations for limited physical activity been made? Yes No
If “Yes”, for how long and why? _____

#2 - Do you recommend this individual for full participation in clinical? Yes No
If “No,” please comment: _____

Health Care Provider Name (please print): _____

Health Care Provider Signature: _____ Date: _____

Address: _____ Phone #: _____

How to Submit WITCC Clinical Health Evaluation

Scan all information as a PDF document and e-mail to: marilyn.west@witcc.edu. The weekly deadline is 7am Friday morning. All information received by the weekly deadline will be reflected in a class update sent to your instructor the following Monday morning.

WITCC Clinical Health Evaluation approved in accordance with CDC guidelines by Mercy Business Health December 2014

Mercy Business Health

To: All WITCC Health Occupation Students

From: Marilyn J. West RN BSN

To provide a safe and healthy environment for you and those you will come in contact with, you must submit a completed WITCC Clinical Health Evaluation prior to your first day of clinical. You will not be cleared to participate in clinical until your WITCC Clinical Health Evaluation is complete. Below are answers to the most commonly asked questions. If you have any further questions, please feel free to contact me at marilyn.west@witcc.edu.

Student Information

Be sure to answer all personal information on the top of the WITCC Clinical Health Evaluation.

Health Care Provider Complete The Following

This part of your WITCC Clinical Health Evaluation is to be completed by a medical doctor, a nurse practitioner or a physician's assistant. No other forms will be accepted.

Measles/Mumps/Rubella (MMR) – You will need to provide one of the following:

- two vaccination dates.
- positive titre for measles, positive titre for mumps and a positive titre for rubella.

Tetanus/Diphtheria (Td) – A Td is current for 10 years.

Chickenpox – You will need to provide one of the following:

- two vaccination dates.
- positive titre.

Hepatitis B (Hep B) – You will need to provide one of the following:

- vaccination dates.
- positive titre.
- signed decline form.

Tuberculin Skin Test (TST) – An initial baseline two-step TST is required. The second TST can be given one week to one year after the first TST as long as the first TST has not expired. A TST is current for one year. The first and second TST must be turned in before the start of clinical. If you have had a past positive TST, you will need to provide documentation of a negative chest x-ray. If the negative chest x-ray is more than one year old, you will also need to turn in a TB Symptom Assessment form.

Please make sure that you keep a copy of your WITCC Clinical Health Evaluation for your own records. In the future, a copy will not be made available to you!

Information About Hepatitis B Vaccine

NOTE: This form should be discussed with the physician of your choice, signed and returned with all other health forms.

The Disease

Hepatitis B is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of infected patients. Most people with Hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people develop chronic active hepatitis and cirrhosis. HBV also appears to be associated with the development of liver cancer.

The Vaccine

Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of purified, inactivated Hepatitis B antigen. It has been extensively tested for safety and efficiency in large scale clinical trials with human subjects. A high percentage of healthy people who receive three doses of vaccine achieve protection against Hepatitis B. Persons with immune-system abnormalities, such as dialysis patients, have less response to the vaccine. Full immunization requires 3 doses of vaccine over a six-month period, although some persons may not develop immunity even after 3 doses. There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time.

Possible Vaccine Side Effects

The incidence of reported side effects is low. A small percentage of persons receiving the vaccine experience tenderness and redness at the site of injection. Low grade fever may occur. Rash, nausea, joint pain, and mild fatigue have also been reported. Few cases of serious side effects have been reported with the vaccine, including Guillain-Barre Syndrome, although the possibility exists that more serious side effects may be identified with more extensive use. You may check with your insurance company concerning coverage.

If you have any questions about Hepatitis B or the Hepatitis B vaccine, please discuss with your physician.

Consent Form

I have discussed with my physician and have read the above statement about Hepatitis B and the Hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccination. I understand that I must have 3 doses of vaccine to confer immunity. However, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I **request** that it be given to me. My decision is voluntary. I understand that all arrangements for receiving the vaccine are my responsibility.

	Date	Lot #	Site	Nurse
_____ Name of Person to Receive Vaccine (Please Print)	(1) _____	_____	_____	_____
_____ Signature of Person Receiving Vaccine	(2) _____	_____	_____	_____
_____ Date Signed	(3) _____	_____	_____	_____

Information About Hepatitis B Vaccine

NOTE: *This form should be discussed with the physician of your choice, signed and returned with all other health forms.*

The Disease

Hepatitis B is a viral infection caused by Hepatitis B virus (HBV) which causes death in 1-2% of infected patients. Most people with Hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people develop chronic active hepatitis and cirrhosis. HBV also appears to be associated with the development of liver cancer.

The Vaccine

Hepatitis B vaccine is produced from the plasma of chronic HBV carriers. The vaccine consists of purified, inactivated Hepatitis B antigen. It has been extensively tested for safety and efficiency in large scale clinical trials with human subjects. A high percentage of healthy people who receive three doses of vaccine achieve protection against Hepatitis B. Persons with immune-system abnormalities, such as dialysis patients, have less response to the vaccine. Full immunization requires 3 doses of vaccine over a six-month period, although some persons may not develop immunity even after 3 doses. There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time.

Possible Vaccine Side Effects

The incidence of reported side effects is low. A small percentage of persons receiving the vaccine experience tenderness and redness at the site of injection. Low grade fever may occur. Rash, nausea, joint pain, and mild fatigue have also been reported. Few cases of serious side effects have been reported with the vaccine, including Guillain-Barre Syndrome, although the possibility exists that more serious side effects may be identified with more extensive use. You may check with your insurance company concerning coverage.

If you have any questions about Hepatitis B or the Hepatitis B vaccine, please discuss with your physician.

Decline to Accept

I have discussed with my physician and have read the above statement about Hepatitis B and the Hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccination. I understand the benefits and risks of the Hepatitis B vaccine and **I do not** wish to receive the vaccine.

Name of Person Declining Vaccine (Please Print)

Signature of Person Declining Vaccine

Date Signed

RETURN E-MAIL TO:

Marilyn West, RN, BSN
Western Iowa Tech
marilyn.west@witcc.edu

Clinical Participation Requirements

WITCC uses external affiliated agencies for clinical experiences for our students. Affiliated agencies may impose requirements for students in order that they be allowed access to clinical experience.

- **Students may be required to provide the following information to external affiliated agencies:**
 - * Health Screening/Immunizations
 - * CPR
 - * Mandatory Reporter
 - * Criminal and Abuse Background Checks
 - * Drug Test
- The student should maintain copies of the documents listed above. *Affiliating agencies may require the student to provide a copy of the documentation.*
- **Drug Testing**
Students may need to consent for drug testing and release of that information to external affiliating agencies for clinical experience. Western Iowa Tech Community College is uncertain of what other drugs may be screened.
- Unprofessional conduct, breach of confidentiality, or performing duties beyond the scope of practice or academic preparation is grounds for immediate removal from the clinical site. Removal will result in failing clinical and may include disciplinary action.

NOTICE AND RELEASE - READ CAREFULLY BEFORE SIGNING

I, the undersigned student in a health occupations program at Western Iowa Tech Community College, understand that participation in a clinical experience is part of the health occupations program and that participation in a clinical experience includes working at an affiliating agency. I further understand that affiliating agencies have the right to establish requirements for participation in clinical experience. I understand that I am responsible for providing copies of the documentation requested by the affiliated agency. I understand and agree that if I am rejected for participation in a clinical experience by an affiliating agency or if I refuse to submit to checks or tests that are required by an affiliating agency in order to participate in a clinical experience, I may be unable to complete my program of study and graduate from a health occupations program. I hereby release Western Iowa Tech Community College, its employees, and all affiliating agencies from any liability with regard to my participation in a clinical experience and decisions made concerning my participation in a clinical experience.

Print name: _____

Student's Name

Program

Date

Confidentiality Agreement

Please read and sign the following statement

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), it is the policy of WITCC that confidentiality and privacy of information is of utmost importance for health occupations students. Confidential information is any client, physician, employee, and business information obtained during the course of your clinical experiences associated with WITCC. Please read and sign the following confidentiality statement.

I will treat all confidential information as strictly confidential, and will not reveal or discuss confidential information with anyone who does not have a legitimate medical and/or business reason to know the information. I understand that I am only permitted to access confidential information to the extent necessary for client care and to perform my duties. Information that may be construed as a breach of confidentiality includes but is not limited to:

1. client's name and other identifying information
2. client's diagnosis
3. type of care being provided
4. reason for seeking health care services, treatment, and response to treatment
5. personal problems or actions

I will not access, use or disclose confidential information in electronic, paper, or oral forms for personal reasons, or for any purpose not permitted by agency policy, including information about co-workers, family members, friends, neighbors, celebrities, or myself. I will follow the required procedures at all agencies to gain access to my own confidential patient information.

In preparing papers, presentations, and other course work I will de-identify protected health information. I will not remove any individually identifiable health information from the facilities in which I am completing my clinical experience. The following are guidelines to be followed in order to be compliant with standards.

- The HIPAA Privacy Rule allows physicians and staff to use and disclose Protected Health Information (PHI) without a patient's written authorization for purposes related to treatment, payment, and health care operations. It further defines "health care operations" to include "to conduct training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers."
- Minimal Information: The amount of PHI used must be the minimum amount necessary to conduct the training. Allowable information can include race, age, other medical conditions, prior medical conditions, and other background information only if necessary to accomplish the prescribed assignment. Do not include the patient's name and medical record number. In addition, do not talk about other identifying characteristics, for example the patient's job, job title, where they work, where they live, their community activities, etc.

HIPAA Program Office; The University of Chicago Medical Center; GUIDANCE (February 18, 2008)

I agree to use all confidential information and the information systems of the facilities I am assigned in accordance with facility policy and procedure. I also understand that I may use my access security codes or passwords only to perform my duties and will not breach the security of the information systems or disclose or misuse security access codes or passwords. I will also make no attempt to misuse or alter the information systems of the facilities in any way.

I understand that I will be held accountable for any and all work performed or changes made to the information systems or databases under my security codes, and that I am responsible for the accuracy of the information I input into the system. I understand that violation of such policies and procedures may subject me to immediate termination of association with any facility, as well as civil sanctions and/or criminal penalties.

Any student who fails to maintain confidentiality and/or directly violates confidentiality may risk expulsion from the program in which they are enrolled.

I have read and understand the WITCC confidentiality policy and agree to abide by the policy as written above.

Print name: _____

Student Signature _____ Date _____

Western Iowa Tech Community College
Nursing and Allied Health
Statement of Knowledge of the Policy and Protocol
for Occupational Exposure to Bloodborne Pathogens

I, _____, have been informed of the potential for exposure to bloodborne pathogens and the risk for disease transmissibility while I am a student in a health occupations program at Western Iowa Tech Community College. I am also knowledgeable of the policies and protocol for an occupational exposure to bloodborne pathogens and hereby agree to abide by them.

Signed this _____ day of _____, 20__

Signature: _____

Program: _____

Social Media Policy

Western Iowa Tech Community College supports the use of technology inside and outside the classroom. This support comes with the expectation that students in WITCC programs will uphold the ethical standards of their prospective professions and the WITCC Allied Health Programs. Federal regulations regarding privacy such as HIPAA and FERPA apply to all personal and academic communication.

No information identifying a patient, patient situation or clinical facility may be posted on any social media website. Social media outlets include but are not limited to: Facebook, LinkedIn, MySpace, YouTube, Twitter, SnapChat and Instagram, etc. Health Care workers have been fired for discussing patient cases on Facebook even though no names were discussed. Student use of photography and/or recording devices is prohibited in all class room, laboratory and clinical sites, unless formal permission of the instructor of record is granted before the fact.

Do not give healthcare advice on social media sites. Students should not become a patient’s “friend” on a social media site.

Any violation of this policy must be reported to the program facility as a possible HIPAA violation. Disciplinary actions will be taken accordingly. Students may be banned from the clinical facility and subject to immediate expulsion from the Medical Scribe Program and subject to potential investigation by the Federal Office of Civil Rights.

Print name: _____

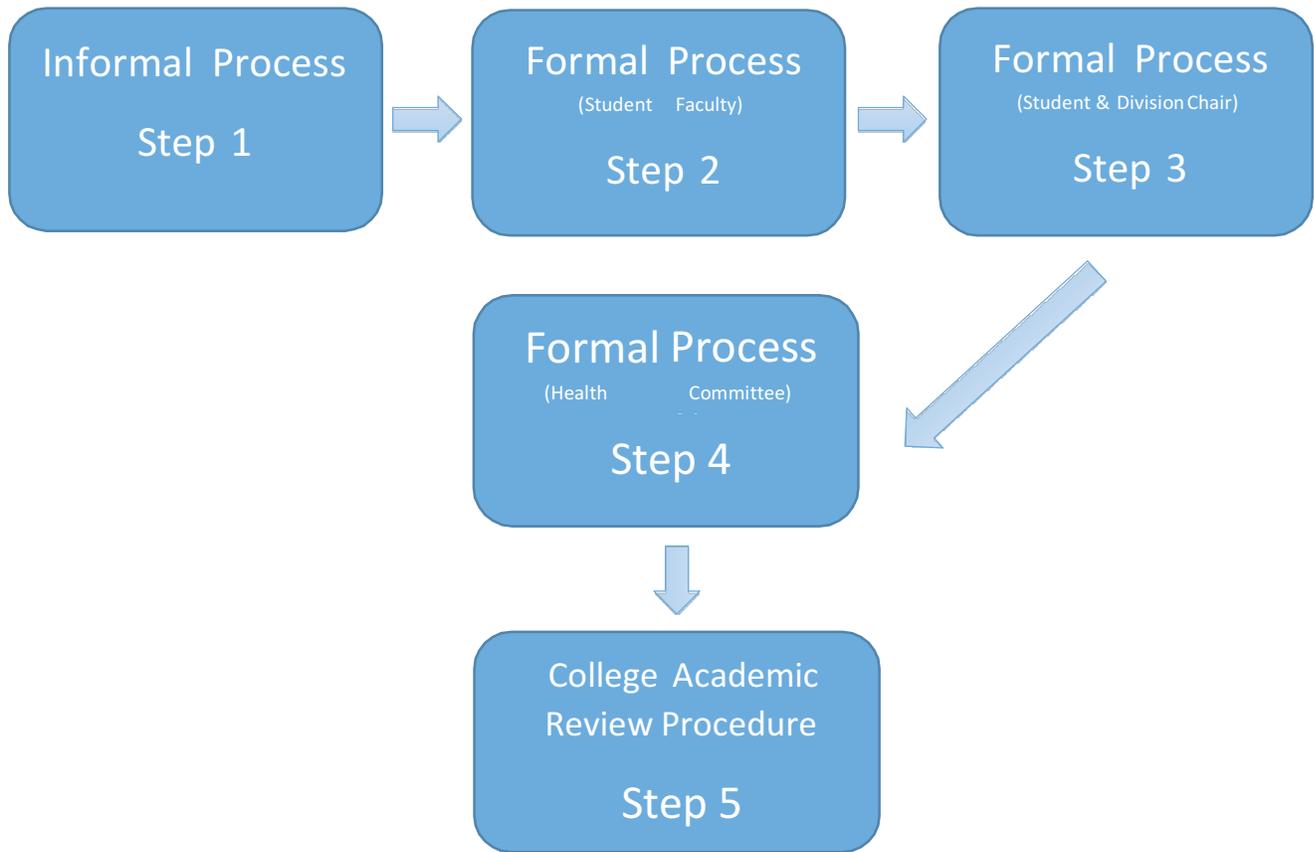
Signature: _____

Witness: _____

Date: _____

**Academic Review Procedure
Program/Course Appeal
Process
Health Sciences Programs**

This process provides students with a mechanism to channel concerns related to departmental/program policies and procedures within the Nursing and Allied Health Departments. These may include concerns and/or violations of department, program, course, laboratory, and/or clinical policies and procedures.



Step 1: Informal Process:

- Students are encouraged to discuss specific concerns with the faculty involved within five (5) instructional days of issue. This is an effort to resolve issue(s) by a prompt and effective means with free and informal communications.
- If at this point, the issue(s) is not resolved to the mutual satisfaction of both parties, the student should proceed to the formal process.
- Documentation of the discussion will be generated. (i.e. email, conference form, etc.)

Step 2: Formal Process: (Student, Faculty)

- Student may initiate a formal appeal process in writing by completing and submitting the “Student Appeal Process Form” to the appropriate faculty.
 - Appeal process form must be submitted within five (5) instructional days of the informal process meeting.
 - Faculty will schedule meeting within five (5) instructional days.
- Faculty may initiate a formal conference with a student to discuss and develop a plan of action related to academic performance, behavior, or discipline.
 - Schedule meeting with student within five (5) instructional days.
 - Documentation: “Student Conference Form”
- If the issue is not resolved, the student may initiate Step 3 of the appeal process.

Step 3: Formal Process: (Student, Department and/or Division Chair)

- If issue is not resolved between student and faculty, the student will request appointment with the respective department and/or division chair within five (5) instructional days.
 - The appeal process request will be submitted by the student in writing to the respective program department and/or division chair.
 - Department and/or division chair will schedule meeting within five (5) instructional days.
 - Documentation: “Student Conference Form”
- If the issue is not resolved, the student may initiate Step 4 of the appeal process.

Step 4: Formal Process (Health Sciences Review Committee)

- If the issue is not resolved, the student may petition to meet with the Health Sciences Review Committee within five (5) instructional days of meeting with department and/or division chair.
 - Student will email request or schedule to meet with Health Sciences Review Committee within five (5) instructional days of meeting with department and/or division chair.
 - Student will submit all prior documentation related to the issue and complete an Updated “Appeal Process” form with email request.
- Health Sciences Review Committee (Associate Dean of Career and Technical Education; Division Chair; 2 health faculty; 1 student)
 - Committee will convene meeting within five (5) instructional days of request.
 - Committee will review documentation and receive testimony from all parties.
 - Committee will render a decision and/or resolution within five (5) days
 - If the student is not satisfied with the resolution, they may initiate the college “Academic Review Procedure”.

Step 5: Formal Process (College Academic Review Procedure)

- Students may initiate the initiate the college “Academic Review Procedure” For procedural step refer to the “College Catalog” and/or “Student Handbook.

**WESTERN IOWA TECH COMMUNITY COLLEGE
HEALTH SERVICES PROGRAMS
STUDENT APPEAL PROCESS FORM**

Student Name _____ **Student ID** _____

Program _____ **Course** _____ **Date** _____

Statement of the issue (problem/concern/complaint/situation) must address the following:

- Clearly and concisely state/describe the resolution you are seeking.
- When did you first become aware of the issue?
- Identify any extenuating circumstances related to the issue.
- What steps have you already taken to address the issue?
- Identify resources or supports that may help you improve or correct the issue.

Resolution (check one):

- Issue resolved
- Issue not resolve; student advised to move to next step – Division Chair.
- Issue not resolve; student advised to move to next step – Health Services Review Committee.
- Issue not resolved; student advised of the College Academic Review Procedure.

Student Signature _____ **Date** _____

Indicates only that student has prepared the documentation and consulted with the faculty.

***Faculty Signature** _____ **Date** _____

Division Chair Signature _____ **Date** _____

Indicates only that student has consulted with Faculty and/or Division Chair and does not indicate, express, or imply approval.

Adopted 11/17/2015
Approved Academic Council 11/24/2015

Signature Sheet of Understanding

I have reviewed, understand, and have had the chance to ask questions about the Medical Scribe Program Admission Information Booklet and agree to abide by these policies.

Print name: _____

Signature _____ Date _____