Beaumont® | HEALTH SYSTEM

STUDENT / INTERN OR WORK OBSERVER AGREEMENT (Document A)

Date: ____________________ Department Name: ____________________

Division/RC: ____________________

School/Program: ____________________ Contact Person: ____________________

Extension: ____________________

____________________ has agreed to intern or observe at Beaumont Hospital as an

Intern or Work Observer from ____________________ until ____________________ . This in no way constitutes "employee" status and may be terminated at any time. With the possible exception of a monthly stipend, this Agreement does not provide for any wage or benefit compensation including health insurance or workers' compensation. It is understood that as a part of this agreement, all background check requirements, as well as all health screenings requirements will be met as outlined in Document B (Health Screening Requirements). While at Beaumont, the student/intern/work observer agrees to remain in compliance with the Beaumont Standards and Code of Conduct, Confidentiality and Systems Usage Agreement.

Signatures required:

____
Intern or Work Observer

____
Parent or Guardian (required if intern or work observer is a minor)

____
Supervisor/Department Manager

____
Employment Manager or Designee

Signatures required if receiving stipend:

____
Corporate Tax Accountant

Stipend is ☐ taxable ☐ non-taxable

____
Administrator

Applicant Information

Name:	Social Security Number:	Date of Birth:
Maiden Name and/or Previous Names Used:		Telephone Number:
Address:		
Email Address:		

HEALTH SCREENING REQUIREMENTS (Document B)

Clearance Requirements:

With Patient Contact (greater than 1 day)	**No Patient Contact/ With Patient Contact** (one day or less)	**No Patient Contact** (2 to 30 days)	**No Patient Contact** (greater than 30 days)
☐ Signed copy of TB test * (current year) ☐ Documentation of current Tdap immunization ☐ Documentation of current influenza immunization ☐ Current year urine drug screen (9 panel) **Required Titer Results **** (within 5 years) ☐ Rubella IgG ☐ Rubeola IgG ☐ Mumps IgG ☐ Varicella IgG or Documentation of two MMR's or two Varicella Vaccinations.	☐ Signed copy of TB test * (current year)	☐ Signed copy of TB test * (current year) ☐ Documentation of current Tdap immunization ☐ Documentation of current influenza immunization	☐ Signed copy of TB test * (current year) ☐ Documentation of current Tdap immunization ☐ Documentation of current influenza immunization ☐ Current year urine drug screen (9 panel)

***TB test must include the following information:**

- Patient's Name
- Dr./Facility Name
- Date Given
- Date Read Result in MM(not positive or negative)

** **For anyone with patient care/contact:** Must have a signed current copy (within 5 years) of the required immunization labs results **(TITERS)** that demonstrate immunity to listed diseases.

Vaccine given: If Applicable

☐ Hepatitis B (not mandatory)
☐ Hepatitis A (mandatory for food handlers only)
☐ Tdap (mandatory)
☐ Influenza (mandatory)

(Physician signature) Date Time

(Printed name)

Received by HR signature Date Time

Sent to OHS (Date) Time

Approved by OHS Signature Date Time