MERCY MEDICAL CENTER
A partnership of
The Sisters of Charity of St. Augustine Health System and UniversityHospitals HealthSystem

VERIFICATION OF FACULTY AND STUDENT COMPLIANCE WITH THE HEALTH CARE REQUIREMENTS SAFETY PRACTICES, CONFIDENTIALITY, HIPAA GUIDELINES HOSPITAL/UNIT SPECIFIC ORIENTATION MERCY MEDICAL CENTER

To: Programs Coordinator, Mercy Medical Center:

I, on behalf of_____, certify that all students and faculty have met the health care requirements, safety practices quiz requirements, understand the confidentiality statement, HIPAA requirements and completed the hospital/unit specific orientation and have been subjected to a criminal background check (Ohio Bureau of Criminal Investigation and FBI within the past 12 months) as stipulated in our contract with Mercy Medical Center to provide clinical experiences.

Signature:_____Program:_____
Date:_____

Contact Person:_____Phone Number:_____

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