UNIVERSITY OF CALIFORNIA, DAVIS HEALTH

EXTERNSHIP PACKET

Thank you for your interest in the externship program at University of California, Davis Health. Externships provide a unique opportunity to gain valuable experience and references through working with a department in your field of study.

The following pages include verification that is required to comply with hospital standards. **You are highly encouraged to start the externship packet at least three months prior to the requested start date.**

Please work with your school coordinator and placement department to complete the externship packet. To aid you in completion of this packet please follow the steps on our website:

Externship Application Process Instructions

https://health.ucdavis.edu/volunteer/opportunities/student-externships

UC DAVIS HEALTH

Externship Application

Personal Information	Notify In case of Emergency
First Name: _____	First Name: _____
Middle Name: _____	Last Name: _____
Last Name: _____	Relationship: _____
Email: _____	Phone: _____
Phone: _____	

STEP 1: Secure Your Placement

UC Davis Health Supervisor:

First Name: _____ Last Name: _____

Phone: _____ E-mail Address: _____

UC Davis Health Dept. /Clinic: _____

STEP 2: Verify Affiliation Agreement

Verify details of your Affiliation Agreement with your school coordinator. Please check our website for a current list of agreements. If you do not find your school listed, please contact your placement department.

Name of School: _____

Program of study: _____

Affiliation Agreement Number: _____ Expiration date: _____

School Coordinator:

First Name: _____ Last Name: _____

Phone: _____ E-mail Address: _____

STEP 3: Complete Outside Clearance Form

Download the Outside Clearance Form. NOTE: This from must be completed by your primary care physician.

STEP 4: Complete Mandatory Training

1. Privacy and Security (print and attach certificate)

2. Mandatory Annual Training Manual (initials required below)

I certify that I have read, understand, and will adhere to the policies and requirements set forth in the Mandatory Annual Training manual. _____ (initial)

If you are a new or current employee, **this form does not satisfy your training requirement**. Please log in to the UC Learning Center for your required courses.

STUDENT SIGNATURE REQUIRED

I hereby agree and acknowledge that I have taken the mandatory training above, which includes Health Insurance Portability and Accountability ACT ("HIPPA") training, and I shall maintain in the strictest confidence any and all patient-specific or confidential, proprietary information which may become known to me by virtue of my participation in any activities relating to my student externship at UC Davis Health. Including, but not limited to, patient-specific data, records, personnel data, internal files, verbal communications and/or other information and I shall not voluntarily disclose directly or indirectly any such information.

I shall make no voluntary disclosures of discussions, deliberations, records or other information expect to persons authorized to receive it in the conduct of the UC Davis Health business. In the event of a breach or threatened breach of this confidentiality agreement the University may, as applicable, and as it deems appropriate, pursue any action available to address such noncompliance. The personal information provided above is true and accurate.

_____ _____

Signature **Date**

UC DAVIS HEALTH

Background Check Authorization Form

Personal Information

First Name: _____ Middle Name: _____

Last Name: _____ Maiden Name/Alias: _____

Date of birth: _____

Address: _____ Apartment number: _____

City: _____ State: _____ Zip Code: _____

Province: _____

Social Security Number (SSN): _____-_____-_____

Email: _____ Phone: _____

Verification Questions

Since your 18th birthday have you ever been convicted or entered a plea of no contest for:

A. A felony?
B. A misdemeanor?
C. A misdemeanor which resulted in incarceration, parole, probation, community service or fees (including DUI)?
D. Have you ever been convicted of any other crime?

__ No, I have never been convicted of any crime __ Yes, I have been convicted of one or more crime (explain below)

If you are under 18 years old, have you ever been adjudicated as an adult of a felony, felony-reduced to a misdemeanor, or misdemeanor by any court?

__ No, I have never been convicted of any crime __ Yes, I have been convicted of one or more crime (explain below)

If you answered "yes" to any of the above please explain the circumstances in detail (when, where, conviction). Failure to disclose information that is found on a background check is grounds to be determined ineligible to extern at UC Davis Health.

STATE PRIVACY NOTICE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves:

The principal purpose for requesting the information on this form is to conduct background checks. University policy and federal statute authorize the maintenance of this information.

Furnishing all information requested on this form is requested. Failure to provide such information shall result in the University obtaining this public information without your authorization.

The University official responsible for maintaining the information contained on this form is the University of California, Davis, Health, Human Resources or Academic Affairs.

This form hereby authorizes the release of my information to Universal™ Background Screening for the purposes of a background check, which includes identity verification, local and federal criminal record, sex offender record, and NCF database check. I hereby certify that all statements on this application are true and correct. I understand that the University of California, Davis solicits this information so as to be informed of my previous record and authorize the use of my information to obtain a consumer report through Universal™ Background Screening. If chosen as an extern, I understand that any falsification of this record may be considered cause of termination. I understand that my externship with the University of California depends upon success completion of a criminal background investigation.

***If under the age of 18, the applicant's parent/legal guardian must ALSO sign and date this form.**

_____ _____

Signature **Date**

UC DAVIS HEALTH

Externship Clearance Form

Student First Name: _____ Last Name: _____

UC Davis Health Department: _____

Name of School: _____

UC Davis Health Supervisor:

First Name: _____ Last Name: _____

Phone: _____

E-mail Address: _____

Once you have completed all items, please forward your completed packet to your UC Davis Health Supervisor. Your packet will be processed for completeness and then approved by your department contact.

UC DAVIS HEALTH PLACEMENT DEPARTMENT REVIEW AND VERIFY

Completed Packet includes ALL of the following documents:

- ☐ Externship Application (page 1, completed and signed/dated by student)
- ☐ Outside Clearance Form (completed and signed by student's physician)
- ☐ Privacy and Security Certificate
- ☐ Mandatory Annual Training Manual (page 1 of this packet initialed by student)
- ☐ Background Check Clearance Form (page 2, completed and signed/dated by student)
- ☐ Externship Clearance Form (page 3, signed/dated by UC Davis Health supervisor)

UC DAVIS HEALTH PLACEMENT DEPARTMENT

I verify that all UC Davis Health externship requirements have been completed as outlined within the externship packet, **I understand that I must keep a copy of the student's Externship Student Checklist and Outside Clearance Form,** and that any copies of the SSN included within the Background check form must be securely disposed.

Please sign and forward pages 2 and 3 of this packet to **hoates@ucdavis.edu** for background check processing.

Expected Start Date: _____ **Expected End Date:** _____

_____

UC Davis Health Department Supervisor

_____ _____

UC Davis Health Department Supervisor Signature **Date**