



(Please Print Plainly)

**Student Information**

Last Name	First	Middle	Student Number.
Present Address	City	State, Zip Code	Telephone Number
Permanent Address	City	State, Zip Code	E-Mail

Areas of Interest:	Start Date:
How were you referred to this facility?	Ending Date:
Long range occupational Goals:	

**EDUCATION / SKILLS**

School	Name & Address of School	Major	Expected Date of Graduation	GPA	Type of Degree pursuing
College					

**LANGUAGE SKILLS (where related to position sought)**

Language:	Do You:	Speak	Read	Write
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**SIGNATURE**

Date: \_\_\_\_\_ Applicant's Signature: \_\_\_\_\_

Any other information you think might be appropriate:

**Upon Completion please  
scan and e-mail to [hr@chadronhospital.com](mailto:hr@chadronhospital.com)  
Fax to 308-432-0441 Attn: HR Department,  
or mail to 825 Centennial Drive, Chadron NE 69337 Attn: HR Department**

**STOP TO BE COMPLETED UPON OFFER AND ACCEPTANCE OF INTERNSHIP**

**HIPAA**

As a Student / Volunteer performing duties at Chadron Community Hospital & Health Services, you will have access to the protected health information of our patients. The fact that an individual is or was a patient of Chadron Community Hospital & Health Services is Protected Health Information.

Federal and State Laws, including HIPAA and our policies and procedures, protect the privacy and security of this protected health information.

It is illegal for you to use or disclose protected health information outside the scope of your student / volunteer duties at Chadron Community Hospital & Health Services. This includes oral, written, or electronic uses and disclosures.

**HIPAA GUIDELINES**

- \* You may use protected health information as necessary to carry out your duties as a student or volunteer.
- \* You may share protected health information with other health care providers for treatment purposes
- \* You may NOT photocopy protected health information.
- \* You may NOT photograph patients.
- \* You must access only the *minimum amount* of protected health information necessary to care for a patient or to carry out an assignment.
- \* You may NOT record protected health information (such as patient names, diagnoses, dates of birth, addresses, phone numbers, Social Security numbers, etc) on any assignments you may need to turn in to your instructor reports you may need to turn in to your program, or forms you may need to take with you.
- \* You may *only* access the protected health information of patients for whom you are caring / volunteering when there is a need for protected health information.
- \* Be aware of your surroundings when discussing protected health information. Ex) because others may overhear you, it is inappropriate to discuss protected health information in elevators, bathrooms, the cafeteria, and other public places.
- \* When disposing of any documents with protected health information, do NOT put them into a waste can. Instead, place discarded documents with protected health information into shredders or containers marked for shredding.
- \* If you have questions about the use or disclosure of protected health information, contact your Chadron Community Hospital & Health Services Coordinator.

**Acknowledgment**

I have read and understand the information. I realize that there are civil and criminal penalties for the unauthorized use and disclosure of protected health information. I will abide by the guidelines when performing my duties at Chadron Community Hospital & Health Services.

Print Name: \_\_\_\_\_  
Intern / Student / Volunteer

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_  
CCH Supervisor

Signature: \_\_\_\_\_

Date: \_\_\_\_\_