

Humboldt State University Pre-Medical Association Internship Program

INTERN CHECKLIST

ORDER OF OPERATIONS:

1. ____ Once assigned a participating physician, read the *Rationale and Rules* thoroughly.
2. ____ Read and sign *Patient Confidentiality Agreement*.
3. ____ Submit *Confidentiality Agreement* to Pre-medical Association ASAP.
4. ____ Contact the office of the participating physician to arrange your internship schedule. Find out if you will need the *Patient Consent Form* - or if they have their own.
5. ____ Upon termination of Internship, get *Physician Faculty Evaluation* along with the stamped envelope to your participating physician.

The Humboldt State University Pre-Medical Association Internship Program is coordinated in conjunction with the Humboldt-Del Norte Medical Society.

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CONFIDENTIALITY AGREEMENT

I, _____ will be participating in the HSU Pre-Medical Association Internship Program in conjunction with the Humboldt-Del Norte County Medical Society. Recognizing the importance of preserving the integrity of the physician/patient relationship, I promise to honor the confidentiality of each patient whose care and treatment I am allowed to observe with the doctor as part of my participating in the program.

I agree that I will not reveal to anyone the names of the individual patients whose care and treatment I observe as a result of my participation in the program, nor will I discuss with anyone any details of the internship experience that might cause any patient's identity to be revealed.

Date: _____

Signature of Intern: _____

Name of Intern (please print): _____

ASSIGNED PHYSICIAN: _____

Please return your completed agreement to a Pre-Medical Association representative as soon as possible. Copies will be forwarded to the Medical Society and sent to the participating physician(s).

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PATIENT CONSENT FORM

Patient Name (please print): _____

Doctor _____ is participating in the Humboldt State University Pre-Medical Association Internship Program in which pre-medical students will be permitted to observe the medical care and treatment provided to his/her patients.

The doctor believes that participation in the program may give these students a better understanding of the physician/patient relationship and of how physicians care for their patients. Therefore, the doctor asks if you would be willing to allow a student observer to be present during the course of your visit. You may choose not to consent to the presence of a student during your visit, and your decision will not in any way affect your care or treatment.

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If you do agree to permit the presence of a student, please read and sign the following authorization.

AUTHORIZATION TO ADMIT STUDENT OBSERVER

I authorize Dr. _____ and the Humboldt State University Pre-Medical Association to permit the presence of a student observer as he/she/they deem fit in addition to physicians and hospital personnel while I am undergoing medical examination and treatment.

Date: _____ Patient's Signature _____