Valley Health System
Clinical Experience Questionnaire and Acknowledgment Form

To prevent the spread of COVID-19 and reduce the potential risk of exposure to our patients, visitors, and healthcare providers, students and faculty participating in any observational and/or clinical programs on-site at The Valley Hospital or any other Valley Health System ("VHS") facility ("Clinical Experiences") are required to complete this form.

Name: _____

School: _____

Valley Department: _____

Personal Phone Number: _____

Self-Declaration.

1. Do you have a fever (temperature of 100.0°F or higher), cough, loss of taste or smell, shortness of breath or other respiratory symptoms or any other COVID-19 related symptoms?
   ☐ Yes ☐ No
2. Have you traveled internationally within the last 14 days?
   ☐ Yes ☐ No
3. Have you had close contact with someone diagnosed with COVID-19 within the last 14 days (unrelated to your job responsibilities as a healthcare worker during which time you were wearing appropriate PPE)?
   ☐ Yes ☐ No
4. Are you currently waiting on the results of a COVID-19 test?
   ☐ Yes ☐ No

If the answer is "yes" to any of the above questions, you may not participate in the Clinical Experience. You further understand that you will be asked the same set of questions at the start of each day of your Clinical Experience and will not be permitted to participate if the answer is "yes" as to any of the above questions.

VHS follows state and federal regulations, as well as Centers for Disease Control and Prevention (CDC) guidelines, and uses personal protection and disinfection protocols to limit transmission of all diseases at The Valley Hospital and all VHS facilities. Although VHS has taken steps to provide protective measures in each of its facilities, due to the nature of the services VHS provides, there is still a chance that you could be exposed to an illness while participating in the Clinical Experience. While rules and procedures may reduce the risk of exposure to and illness from infectious diseases, you acknowledge that the risk of serious illness and death still exists.

By signing below, you acknowledge that COVID-19 has been declared a worldwide pandemic, is extremely contagious and can spread from person-to-person contact. You agree to follow all applicable VHS policies and procedures and CDC guidelines to reduce the spread of COVID-19, which includes, without limitation, policies regarding the following: washing your hands before participating in and frequently throughout any Clinical Experience, maintaining social distancing of 6 feet, and wearing surgical masks while participating in the Clinical Experience (except where doing so would inhibit your health). By signing below, you acknowledge that you understand the contagious nature of COVID-19 and voluntarily assume the risk that you may become infected, exposed, or otherwise contract COVID-19 while participating in the Clinical Experience.

I WILL REFRAIN FROM MY CLINICAL ROTATION IF I BECOME ILL AND WILL IMMEDIATELY NOTIFY MY SCHOOL OF A CHANGE IN MY CONDITION. I ACKNOWLEDGE THAT I HAVE THOROUGHLY READ THIS FORM IN ITS ENTIRETY, THAT I UNDERSTAND IT AND THAT I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS.

_____ _____
Signature of Student/Faculty Date

_____
Parent/Guardian Name (if Student is under 18)

_____ _____
Signature of Parent/Guardian (if applicable) Date