CLINICAL INTERNSHIP/SHADOWING CHECK LIST: Prior to applying to graduate programs in *any* health care field, you should gain experience interning/shadowing with health professionals.

Due to privacy and liability concerns, most hospitals will have requirements you must fill prior to even shadowing with their physicians. *Unless the shadowing is part of a course for credit at Wofford, the College is not involved in these arrangements; they are strictly between you and the hosting hospital or clinic. Your premed advisor can assist as needed but any compliance with a host institution's regulations, whether imposed internally or in compliance with state and federal law, rests solely with you.*

For our clinical internships interim course, we have made arrangements with Spartanburg Regional and Mary Black to "certify" that students have met a certain set of requirements, listed below. If you're arranging shadowing at these hospitals on your own, you can get a head start by working through this list. Have all documentation sent to Dr. Moeller or Dr. Moss at Wofford, either by mail, fax, or email.

Dr. Moeller' email: moellerjf@wofford.edu

Dr. Moss' email: mossre@wofford.edu

Bio dept fax: 864-597-4629

We will keep all documentation on file in the biology department, for when you need it forwarded to clinicians or hospitals.

Other than providing the documents listed below at your request, Wofford cannot provide "contracts" or "certifications" for your clinical experiences.

Documentation required by Spartanburg hospitals:

1. _____Criminal Background Check: We use Surveillance, Resources & Investigations in Greenville: 864-232-4140. The cost will be approximately $35-$40 [included in the clinical internships interim costs]

2. _____PPD Skin Test (2 step), within the previous 12 months. You can get this at Student Health, or the Department of Health, or your doctor's office. You'll need to request documentation of your negative test, sent to Dr. Moeller or Dr. Moss.

3. _____Evidence of Measles & Rubella immunity: Your parents might have a vaccination record for you; otherwise your physician will have one for you.

4. _____Evidence of Chicken Pox immunity; or a "reliable oral history": if your parents are certain that you've had chicken pox, that will be fine.

5. _____Evidence of Hepatitis B vaccination

6. ____Negative Drug Screening, for "10 Panel A". We use "Definitive Wellness" in Greenville: 864-640-8154. Their office is in Greenville, but they are also in Spartanburg. You'll have to give a urine sample at their facility. Bring the attached form when you go. The cost will be approximately $25-$30 [included in the clinical internships interim costs].

7. ____ Hospital orientation: You'll have to satisfy the orientation requirements for the relevant hospital. Once you have satisfied steps 1-6 above, Ms. Thomas, Dr. Moeller or Dr. Moss will give you the email address of our contact at the hospitals.

Definitive Wellness
38 Boland Court Suite 106
Greenville, South Carolina 29615
864-640-8154
Fax: 864-990-2249

Results Reporting Form

Step 1: To be completed by the *collector or employer representative*.

Company Wofford College | Account# Student will pay
Facility Dept of Biology | Fax # 864-597-4629
Authorizing Person | Phone # 864-597-4620

Step 2: To be completed by the *donor*.

Donor Name _____ SS# _____

Reason for Testing: ☒ Pre-Employment ☐ Random ☐ Return to Duty ☐ Post- Accident
☐ Suspicion/Cause ☐ Follow Up ☐ Other

I certify that I am about to provide my urine specimen to the collector, I will not adulterate my specimen in any manner, and the information provided on this form is correct. I hereby consent to this test, release and hold harmless the employer and test facility and give permission for the results of this/these test(s) to be given to my employer, perspective employer, or employer agents.

Donor Signature _____ Date _____

Step 3: To be completed by *collector.*

I certify that the donor's identification has been positively verified and that the specimen(s) identified on this form is/are the specimen(s) that the donor provided. I certify that I have used the specimen(s) received from the donor and that I have conducted, obtained, and recorded the screening test reults listed below.

Collector's Signature _____ Date _____

Level of Screening: ☐ 5 Panel A ☐ 6 Panel A ☒ 10 Panel A ☐ Breath Alcohol
☐ 5 Panel B ☐ 6 Panel B ☐ 10 Panel B
☐ 5 Panel C

Step 4: To be completed by *testing personnel*.

	Negative	Non-Neg	N/A
All Drugs Negative	☐	☐	☐
Cocaine (COC)	☐	☐	☐
Amphetamines(AMP)	☐	☐	☐
Methamphetamines(mAMP)	☐	☐	☐
Marijauna (TCH)	☐	☐	☐
Opiates (OPI)	☐	☐	☐
Phencyclidine (PCP)	☐	☐	☐
Benzodiazepines(BZO)	☐	☐	☐
Barbituates(BAR)	☐	☐	☐
Methadone(MTD)	☐	☐	☐
Methylenedioxymethamphetamine(MDMA)	☐	☐	☐
Breath Alcohol (BAC)	☐	☐	☐

Confirmation Test(s) Requested

☐ Cocaine (COC)
☐ AmphetaminesAMP)
☐ Methamphetamines(MET)
☐ Marijauna (TCH)
☐ Opiates(OPI)
☐ Phencyclidine (PCP)
☐ Benzodiazepines(BZO)
☐ Barbituates(BAR)
☐ Methadone(MTD)
☐ Methylenedioxymethamphetamine(MDMA)
☐ Other _____

Follow-up Actions Required

☐ None, this drug/alcohol screen result was negative.
☐ None, no additional laboratory test(s) are authorized by employer/requestor.
☐ Additional laboratory test specimen(s) will be collected and processed
☐ This speciman will be sent to the laboratory for confirmation.

DW-10

AUTHORIZATION FOR RELEASE OF INFORMATION FOR INVESTIGATIVE CONSUMER REPORT

PRIVACY ACT STATEMENT

In compliance with the Privacy Act of 1974, the following information is provided: Basic authority for collecting the requested information is contained in E.O. 12450:5 USC 1303-1305; 42 USC 2165 and 2455: 22 USC 2585 and 2519: and 5 USC 3301. This form will be furnished to individuals and organizations for the purpose of obtaining information from them about you and your activities in connection with an official background investigation concerning: (1) fitness for employment, (2) clearance to academic program, (3) security clearance or access to sensitive materials, or (4) any other legitimate purpose within the scope of employment responsibilities. Furnishing the requested information is voluntary, but failure to provide all or part of the information may result in a lack of further consideration for enrollment, clearance or access, or in the termination of your academic enrollment.

Name of College: _____ **Program/Department**: _____

In relation to my academic enrollment/participation, I authorize Surveillance, Resources and Investigations, LLC (SR&I, LLC) to construct an investigative consumer report with information pertaining to my background, reputation or disposition, including, but certainly not limited to, facts involving my employment, education, social security number authentication, driving record, consumer credit history, criminal record history and/or additional public records history. I authorize all parties to release all information applicable to this investigation. I release from liability all persons, governmental agencies, as well as other companies and agencies disclosing any and all information. In addition, I authorize that photocopies of this form may be considered as an original.

I have read, comprehended and authorize, any person, company or other entity contacted by Surveillance, Resources and Investigations, LLC (SR&I, LLC), to provide the information stated above.

THIS FORM WILL NOT BE ACCEPTED IF ILLEGIBLE, ALTERED OR INCOMPLETE.

	- -		
Signature	**Social Security #**	**Driver's License #**	**DL State**

Print Last Name	**First Name**	**Middle Name**	**Maiden/other**

		Present
Current Street Address	From Date	To Date

City	**State**	**Zip**	**County of Residence**

HAVE YOU RESIDED WITHIN SOUTH CAROLINA FOR 12 MONTHS? **YES / NO**

HAVE YOU RESIDED WITHIN TWO DIFFERENT STATES WITHIN THE LAST 12 MONTHS? **YES / NO**

HAVE YOU WORKED WITHIN TWO DIFFERENT STATES WITHIN THE LAST 12 MONTHS? **YES / NO**

IF YES, LIST STATES: _____

Prior Addresses for Past Ten Years (attach additional pages if need)

City	State	County	Dates: From	To
City	State	County	Dates: From	To

HAVE YOU EVER BEEN CONVICTED OF A CRIME OTHER THAN MINOR TRAFFIC VIOLATION? **YES / NO**

*This information will only be used to complete the background check process and help avoid misidentification.

Date of Birth: ____/___/_____ Gender (M or F): _____

Please send signed form to: **SR&I, LLC.**
P. O. Box 5106, Greenville, SC. 29606 or Via Fax: 864-232-4140