ACMC
ASHLEY COUNTY
MEDICAL CENTER

Community Health Applied in Medical Public Service
CHAMPS

March 16, 2022

CHAMPS applications are now available!

CHAMPS, Applications, is a ONE-week summer enrichment program for students who have completed 8th or 10th grades and are interested in pursuing a medical career. This year's CHAMPS will take **place June 20 – June24, 2020** at Ashley County Medical Center

During the one weeks, students will take part in the following activities:

- Receive CPR & First Aide training and certification
- Learn the laparoscopic surgical machine
- Apply casts to one another after learning about orthopedics
- Tour Lab areas and the Emergency Department at local medical facilities
- Tour state of art Radiology Department
- Receive education about personal choices such as Nutrition, Alcohol and Drug Abuse, Organ Donation and more
- Take part in team building exercises
- Learn Basic nursing skills
- Much, much more!

Please help us to find those students that are interested in a career in the medical field and would be a great fit for this program. Students must possess a minimum GPA of 2.75 and **committed to attending the full week** to apply for this program. Many students apply, but only 10 students will be available. Students are chosen based on academics, extra-curricular activities, community involvement, teacher recommendations, personal essay, and work ethic. All details are found on the application. Completed applications are due no later than **April 29, 2020** and can be submitted by fax, mail, or hand delivery. FAX 870-364-1245, Mail: Ashley County Medical Center P.O. Box 400 Crossett, AR 71635 or delivered to the school councilor or delivered to Ashley County Medical Center.

This camp is provided FREE of charge to these students thanks to the support of the CHAMPS Partnership, as well as the partnerships with area healthcare organizations and local vendors. All Students will be COVID Vaccinated or have an approved Medical Exemption or Religious Exemption by our COVID review committee.

For more information about CHAMPS, contact Shawna Hawkins CHAMPS Director at 870-364-0563 or Shirley White at 870-364-1272.

Thank you for your help and your continued support of this program!

Shawna Hawkins
Ashley County Medical Center Education Manager

CHECK LIST OF ITEMS NEEDED TO ATTEND THE CHAMPS PROGRAM.

- ☐ Completed Application by April 29, 2020
  - ☐ Parent and Guardian Information form
  - ☐ Student Writing Section
  - ☐ Signed Disciplinary Policy
- ☐ Teacher recommendation form
- ☐ School Counselor academic endorsement / copy of student transcript
- ☐ Signed Confidentiality Agreement
- ☐ Signed Parental/Guardian consent
- ☐ Signed Photography Release Agreement
- ☐ Copy of COVID vaccination or
- ☐ **Fully completed Medical Exemption Request (3 pages) or Religious Exemption Request form (2 pages) (Exemption requests must be approved by the ACMC Review Committee before student is allowed to attend)**

Community Health Applied in Medical Public Service

ASHLEY COUNTY MEDICAL CENTER
APPLICATION FORM 2022
6/20/22 – 6/24/22

DEADLINE TO APPLY: APRIL 29, 2020

Please print clearly

STUDENT:

1. Name: _____
   Last *First* *Middle initial*

2. Gender (Circle one): Male / Female

3. Race (Check one):
   - □ White
   - □ Black/ African American
   - □ American Indian or Alaska Native
   - □ Asian
   - □ Native Hawaiian or Other Pacific Islander
   - □ Other:

   Please specify _____

From Disadvantaged Background? (Circle one) Yes / No / Unsure
Medically Underserved Community? (Circle one) Yes / No / Unsure

**Explanation -

Disadvantaged
- 1st Generation to attend college
- From high school with low SAT/ACT Scores or below the average state test results (School's numbers)
- From school district where 50% or less of graduates go to college
- Diagnosed physical/mental impairment that substantially limits participation in education experiences
- English is not primary language and language is still a barrier to academic performance

Medically Underserved
- There is a shortage of physicians per the number of people in your community

Hometown location (Circle one) Rural / Urban

4. Date of Birth: _____/_____/_____ Last Four digits of your Social Security number: _____
   Month *Day* *Year*

5. Do you go by a different name? (Nickname) If so, what is it? _____

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6. Home Address: _____
Street or P.O. Box

_____
City *State* *Zip code*

7. Home phone number: _____ Cell phone number: _____
Area code/number (xxx) xxx-xxxx *Area code/number (xxx) xxx-xxxx*

8. E-mail address: _____ (if you don't have one, create one)

STUDENT INFORMATION

9. Name of High School: _____

10. Year You Will Graduate: _____

11. T-shirt Size (circle one): S M L XL 2X

12. What health career are you MOST interested in? _____

13. Please list any food allergies or dietary restrictions you have: _____

14. Do you have any medical conditions, including pregnancy, we should be aware of? □ Yes □ No

*If yes, please specify: _____

*Please note: For your safety, we ask that you tell us about any medical conditions. This information will NOT disqualify you from the program.

STUDENT INFORMATION

15. Areas of interest for job shadowing: (If you are having shadowing)

1. _____
2. _____
3. _____

PARENT or GUARDIAN Information

16. Name: _____

17. Home Address: (Write Same if it is the same as the student)

_____

_____

18. Home/Work phone number: _____ Cell phone number: _____
Area code/number *Area code/number*

STUDENT WRITING SECTION

19. List your significant SCHOOL activities, achievements and awards of the past two years:
(Please write neatly. Attach another sheet of paper if necessary.)

20. List your significant NON-SCHOOL (community, church, etc.) achievements of the past two years. Also, describe any jobs or duties you have at home or school that demonstrate your level of commitment to a task. (Attach another sheet of paper if necessary).

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STUDENT WRITING SECTION

21. Please write in your own words why you are interested in attending CHAMPS and why you want to learn about health careers. Your response to this question is very important in the selection process. If you need more room, attach another page to your application.

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DISCIPLINARY POLICY

CHAMPS faculty and staff aim to maintain a safe, positive, and educational environment for all participants. Certain behaviors can result in your immediate dismissal from the CHAMPS program and the notification of your parent/guardian. These behaviors include, but are not limited to:

- Deliberate violation of UAMS's or ACMC safety rules or policies
- Possession of alcohol and/or illegal drugs
- Being intoxicated or under the influence of any controlled substances
- Use of tobacco products or e-cigarettes during program hours
- Violation of dress code or cell phone policy
- Inappropriate language or discussions
- Violation of HIPAA rules and regulations
- Harmful or inappropriate contact or communication with other participants and/or staff
- Deliberate destruction or damage to property
- Unexcused tardiness or absence

STUDENT ACCEPTANCE STATEMENT

All your expenses for CHAMPS are being paid by the CHAMPS Partnership, which includes Arkansas Farm Bureau, UAMS and county Farm Bureau organizations. If accepted into the program, you agree to attend the full length of the program (1 week) and to abide by the disciplinary policy. **Please note that this is a day program and that transportation to and from each daily session is your responsibility.**

Signed: _____ **Date:** _____
(Student)

PARENT/GUARDIAN PERMISSION STATEMENT

I hereby grant permission for my son/daughter to apply to this program and for school officials to report my child's achievement and grades. I understand that if my son/daughter is accepted, we will be responsible for his/her daily transportation for the two-week program.

Signed: _____ **Date:** _____
(Parent/Guardian)

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CHAMPS SCHOOL RECOMMENDATION FORM

(CONFIDENTIALITY WILL BE HONORED REGARDING INFORMATION SUPPLIED BY SCHOOL PERSONNEL)

1. Student Name _____
(First) (Middle) (Last)

2. School Name:_____ School District_____

3. School Address_____
(Street or P.O. Box) (Town) (Zip Code) (County)

4. TEACHER: THIS INFORMATION IS CONFIDENTIAL. Please state why you think this student would benefit from participating in CHAMPS. Comments should be made regarding the student's abilities and potential for success in a health care environment. Use the space provided, then sign at the bottom of this page.

_____ _____
Teacher's signature Today's date

Printed Teacher Name _____

Email _____

What subject do you teach? _____

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SCHOOL COUNSELOR ACADEMIC ENDORSEMENT

Student Name _____
(First) (Middle) (Last)

I have discussed pertinent information on this form with this student and agree that he/she is genuinely interested in participating in the CHAMPS program.

_____ _____
Counselor's signature Today's date

_____ _____
Counselor's Printed Name Counselor's Email

Student's Cumulative GPA _____

Attach a legible transcript of this student's grades to this form. Please include any citizenship grades or comments or ACT scores.

Note: this student must have taken BIOLOGY (or be currently enrolled) in order to be considered for CHAMPS.

PLEASE ATTACH COMPLETED APPLICATION, TRANSCRIPT (MUST INCLUDE CUMULATIVE GRADE POINT AVERAGE) **AND SIGNED CONSENT FORMS BY April 29, 2022 TO YOUR GUIDANCE COUNSELOR.**

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Confidentiality and Hold Harmless Agreement (Minor)

As the undersigned parent(s) or legal guardian(s) of _____, a minor child, I (We) hereby consent to the participation of said child in a volunteer program and tour other associated Hospital or Facility through the volunteer program. I (We) understand and agree that said child is to abide by all rules and requirements requested by ACMC and UAMS and to conduct herself/himself in an appropriate manner.

I (We) understand that in the course of the child's participation in this program and tour, he/she may have incidental exposure to confidential information. Confidential information includes all patient, employee, and student information and information of a proprietary, trade secret or otherwise confidential nature. I (We) agree that, during the child's participation in the program and after the conclusion of the program, said child will not disclose the confidential information to anyone, including myself/ourselves, in any way or in any form without the specific written authorization of ACMC or UAMS except as may be required by law.

I (We) hereby consent to and expressly authorize the release of said child's name, hometown and the name of the school said child attends while child is participating in the program. I acknowledge that ACMC and UAMS may release this information to stakeholders of the CHAMPS* or Mini CHAMPS Programs and others UAMS deems necessary to further the program. I acknowledge that this is a limited release of confidential student information under the Family Educational Rights and Privacy Release Act ("FERPA").

I (We) understand that there are certain risks inherent to and associated with the activities of any facility in which patient care and research are conducted. I (We) agree on behalf of said child to the assumption of those risks and to not hold the University of Arkansas or its officers, board members, agents or employees responsible for any harm or injury from any cause, which may befall said minor child related to or arising out of the child's participation in the program and/or tour of UAMS or associated facility or hospital and hereby release said entities and persons from any liability relating thereto. I (We) further agree to indemnify and hold said entities and persons harmless from the claims or causes of action asserted by any other person on behalf of said child, or in their own right, arising out of said participation. I (We) similarly agree to hold said entities and persons harmless from the claims of other persons arising out of any acts done by me, said child. I (We) understand and agree that this Agreement is not intended to include a release from harm caused by an individual's criminal conduct or by the conduct of an individual constituting an intentional tort recognized under Arkansas law; and any such criminal conduct or intentional tort is against ACMC or UAMS policy and therefore outside the scope of the person's employment or relationship with ACMC and UAMS for which ACMC and UAMS is not vicariously liable. I (We) agree that these conditions and agreements are binding on all of my (our) heirs, executors, administrators, representatives, assignees and successors in action.

I (We) have read and understand the above and willingly agree to said terms and conditions. This authorization was signed voluntarily with the express understanding that this release will allow access by certain individuals to limited student information about said child that participates in this program.

Signature _____ Date: _____

State relationship to child: _____

Signature _____ Date: _____

State relationship to child: _____

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Parental/Guardian(s) Consent for Student Participation in CHAMPS*

Name of Child: _____ Last four digits of Social Security Number: _____

I understand that my child has been selected to participate in the Medical Applications of Science to Health (CHAMPS*) Program at Ashley County Medical Center CHAMPS and I hereby give my permission for my child to participate in this program. I agree to execute the Confidentiality and Hold Harmless Agreement and to make my child aware of his/her responsibilities included in the Agreement. _____ Initial

I am aware that regular attendance at the CHAMPS* Program and adherence to both Ashley County Medical Center and UAMS policies and procedures will be required of my child, to follow the protocols, including any Covid-19 protocols such as mask and social distancing requirements. Proof of vaccination before camp date or a medical or religious exemption completed and approved before the camp start date. _____ Initial

I authorize Ashley County Medical Center and UAMS to release my child's name, hometown and the name of the school my child attends while participating in the CHAMPS Program to certain stakeholders of the program and others as they deem necessary to further promote the program. _____ Initial

I understand that it is my child's responsibility to become familiar with all orientation materials. _____ Initial

I give my permission for my child to participate in a Cardiopulmonary Resuscitation (CPR) course, which may include a risk of physical strain, the possibility of cross infection, or emotional stress. If my child has a medical history that may be aggravated by this course, I will consult his/her physician to determine if my child should participate in the CPR course. _____ Initial

I understand that various departments and clinical services at Ashley County Medical Center and UAMS Medical Center may allow my child to observe and participate in available and appropriate activities. _____ Initial

I consent to and authorize Ashley County Medical Center and UAMS to use my child's photograph for education and public relations purposes related to the CHAMPS* Program. _____ Initial

I am aware that my child will be expected to follow instructions, to be punctual, to be courteous, and to avoid unsafe acts. This will include respecting confidentiality, following a specified dress code, and refraining from using a cell phone during the program. I understand that violations of these rules may result in dismissal of my child from the program. _____ Initial

Please sign after you have read and initialed all the above statements.

Print Name: _____ Relationship to Child _____

Signature: _____ Date: _____

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Photography Release Agreement

I, the undersigned, hereby give the University of Arkansas for Medical Sciences, their legal representative, assigns, and those acting on their behalf and with their permission, the right and permission to copyright in any part of the world, to use, reuse, publish and republish, in conjunction with my own or fictitious name, any photograph, film or video tape recording taken of me by the University of Arkansas for Medical Sciences or those acting on their behalf or with their permission, and any reproductions thereof, in any form, whether intentional or otherwise, and may be used in conjunction with any advertising material, for any purposes of trade, advertising, exhibit, publicity, or promotion, without restriction or limitations. I understand that the photographs, film and/or video may be used in news releases, newspapers or magazine articles, television, the ACMC and UAMS website or social media sites (e.g., Facebook, YouTube).

I hereby release, discharge, and agree to save harmless ACMC and the University of Arkansas, their assigns, legal representatives, agents, and those acting on their behalf and with their permission, from and against any liability resulting from any distortion, blurring, alteration or use in composite form, whether such was intentional or otherwise, which my occur, result, or be produced in the taking of said photography, or by processing or reproduction of the finished product, its publication or the distribution of same.

I waive the right to approve or inspect the recordings, advertising copy, or material used in conjunction therewith.

I hereby warrant that I have read this agreement in its entirety before affixing my signature thereto, and I fully understand the contents therein. I further warrant that I am of legal age and competent to contract my own name as far as the above is concerned.

DATE _____

PRINT NAME _____ SIGNATURE _____

I warrant that I am the parent and/or guardian of:

PRINT NAME _____
the person named in the foregoing Release Agreement, and that I am duly authorized to act in his/her behalf. I have read the foregoing agreement in its entirety and I understand its contents. I hereby consent that the photography taken under this agreement may be used for the purposes set forth therein.

DATE _____

PRINT NAME _____ SIGNATURE _____

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Hwy.82 East · 1015 Unity Road · P.O. Box 400 · Crossett, Arkansas 71635 · 870-364-4111 · Fax 870-364-1245

Medical Exemption Request

REVISED: 11/17/2021

This form relates to your request for an accommodation/exemption from the CMS COVID-19 vaccination requirement. COVID-19 is a highly communicable, infectious, and serious disease that can lead to hospitalization and sometimes even death. Anyone can get COVID-19, including people who are otherwise healthy. Requiring vaccination against COVID-19 demonstrates our commitment to protect the safety and health of our employees, visitors, and our patients, many of whom may have weakened immune systems, as well as our own families.

Individuals requesting a medical accommodation must complete this form per the instructions below. In order to qualify for the exemption, employees are required to provide a written and signed statement below objecting to immunization due to medical reasons.

INSTRUCTIONS:

- If you are seeking a **medical accommodation**, you must complete and submit the form to your licensed healthcare provider (physician or RNP). Your licensed healthcare provider must complete, sign, date and return the form to you before you submit the request.
- You must then submit the completed request form to the Chief Compliance Officer.
- Upon review of the completed form and documentation, you will be notified of the decision regarding your requested accommodation.
- All incomplete forms will be denied for requested accommodation.

PART 1 – MEDICAL ACCOMMODATION REQUEST:

Name _____ Date of Request _____

Position _____ Department (if applicable) _____

Please provide the qualifying medical condition that a medical provider considers a contraindication to the COVID-19 vaccine, consistent with CDC guidance (Use space below and additional sheet(s) as needed). Also include any alternate accommodations you are requesting which you believe might address your needs.

_____

_____

_____

_____

_____

_____

_____

_____

(Please ensure your healthcare provider completes Part 2 of this form.)

I am requesting an exemption from the required vaccination due to my medical conditions that prevent me from being vaccinated.

I verify that the above information is complete and accurate, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others and/or to me, or if it creates an undue hardship on Ashley County Medical Center.

_____ _____

Signature **Date**

PART 2 – HEALTHCARE PROVIDER CERTIFICATION:

Please provide the following information:
Note to Provider: Please answer, fully and completely, all applicable parts. Please attach any supporting documentation as appropriate.

Name of Patient: _____

Patient should not be immunized for COVID-19 for the following reason(s): (Please be as specific as possible including the medical condition that is a contraindication for the COVID-19 vaccine(s) consistent with CDC guidance and the duration of the qualifying medical condition.)

This exemption applies to: (check all that apply)

- ☐ Pfizer-BioNTech Vaccine
- ☐ Moderna TX, Inc. Vaccine
- ☐ Janssen/Johnson & Johnson Vaccine

I certify that Patient has the above contraindication and recommend that they not receive the COVID-19 vaccination as a result of the above contraindication.

Healthcare Provider's Name (please print)	Specialty

Street Address

City, State, Zip

Healthcare Provider's Signature	Date

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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Religious Exemption Request

REVISED: 11/17/2021

Title VII of the Civil Rights Act of 1964 prohibits discrimination on the basis of religion and promotes diversity and inclusion for employees as part of its commitment to equal employment opportunities.

The purpose of this form is to assist in establishing the basis of sincere religious belief, observance or practice. Health Care Providers are required to provide a written and signed statement objecting to immunization due to sincerely held and genuine religious beliefs, observances or practices which conflict with the COVID-19 vaccine. The statement must address all of the following elements:

1. Describe the nature of your objection to the COVID-19 vaccine requirement.
2. Would complying with the COVID-19 vaccination requirement substantially burden your religious exercise or conflict with your sincerely held religious beliefs, practices or observances? If so, please explain how.
3. Please provide any additional information that you think may be helpful in reviewing your request. For example:
    - How long have you held the religious belief underlying your objection?
    - Whether your religious objection is to the use of all vaccines, COVID-19 vaccine or some other subset of vaccines.
    - Whether you have received vaccines as an adult against any other diseases (such as flu or a tetanus vaccine).

INSTRUCTIONS:

- If you are seeking a **religious accommodation**, you must complete the entire form.
- You must then submit the completed request to the Chief Compliance Officer in a sealed envelope.
- Upon review of the completed form and documentation, you will be notified of the decision regarding your requested accommodation.
- All incomplete forms will be denied for requested accommodation.

_____ _____

Name Date of Request

_____ _____

Position (if applicable) Department (if applicable)

Please explain why you are seeking a religious accommodation (use space below and additional sheet(s) as needed). In addition, please provide any documentation of religious exemptions/accommodations that have been previously provided to you by other employers.

_____

_____

_____

_____

In some cases, Ashley County Medical Center will request documentation or other authority of your religious practice(s) or belief(s).

It will be helpful if you provide:

1. A clear individual statement of your sincerely held religious belief, observance or practice.
2. A statement from clergy, bishop, pastor, an individual or group familiar with your sincerely held belief, observance or practice.
3. Provide detailed information how your sincerely held religious belief, observance or practice conflict with the COVID-19 vaccine.

If requested, can you provide documentation or other authority to support the need for an accommodation from the vaccine due to your religious practice(s) or belief(s)? Yes____No____

I am requesting an exemption from the required vaccination due to my sincerely held religious belief, observance, or practice that prevents me from being vaccinated.

I verify that the above information is complete and accurate, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action.

I also understand that my request for an accommodation may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others and/or to me, or if it creates an undue hardship on Ashley County Medical Center.

Signature **Date**