

2024 LAB CAREER CAMP

Future Laboratory Professionals: Without the Lab, They're Only Guessing!

Regional Medical Center (RMC) is excited to be able to offer a Laboratory Career Camp, “*Future Laboratory Professionals: Without the Lab, They're Only Guessing!*” for students (ages 14-18; must have finished 8th grade). This camp offers a unique opportunity to learn about a laboratory career through interactive presentations and hands-on learning.

Activities include interacting with a simulation manikin to learn how to draw blood samples from a patient, learning routine laboratory techniques such as pipetting, differentiation of blood cells, staining bacteria and collecting culture samples. Learning blood types and how to match that blood type to give blood to a patient, how to perform routine urinalysis procedures and even the lab's role in determining the culprit in a mock crime scene investigation are included.



The 4-day program will be offered June 10-13, 2024 from 9AM-2PM.

Bring sack lunches or students can purchase lunch from our public cafeteria. Students **MUST** be available to meet each day for the entire time. Class size is limited. The cost is \$25 per student, payable on the first day of camp to RMC. If the cost of camp would cause hardship, please check the box on **Application for Participation** and tuition assistance information will be provided.

The following items should be completed and returned to RMC by Monday, May 13, 2024. Items postmarked **after** Monday, May 13th will **not** be eligible for the summer 2024 camp.

- Application for Participation
- Letter of Recommendation Form
- RMC Marketing/Promotional Material Release Consent Form
- RMC Confidentiality and Security Agreement

All items should be returned in a sealed envelope to the address and attention below.

ATTN: Ann Wilson-Grant/Shea Putz
Regional Medical Center
709 West Main Street, PO Box 359
Manchester, IA 52057

Students will be notified via email on Monday, May 20th with acceptance or declination of the camp.

For more information to explore this opportunity, please contact Ann Wilson-Grant at 563-927-7489 or ann.wilsongrant@regmedctr.org.

LETTER OF RECOMMENDATION

Please print legibly.

Student Name (First & Last): _____

Step 1: We are curious why you are potentially interested in a career in Laboratory Science and how the Lab Camp at Regional Medical Center can be a benefit to you. Please provide a detailed answer to the following questions. You may type your answer on a separate sheet of paper if desired.

Why are you interested in Laboratory Science? What is it about your life experiences, your talents, your personality that has potentially led you to this career path?

Step 2: Have a teacher, coach, guidance counselor, employer, volunteer, supervisor or mentor (non-family adult) who knows your goal of potentially becoming a lab tech complete the section below.

Please evaluate the student on the following qualities.

Qualities	Exceptional	Above Average	Average	Below Average
Dependability				
Trustworthiness				
Acceptance of Others				

How are you associated with the student? _____

Based on your association you have had with the student, please describe why this student should participate in Lab Camp at Regional Medical Center.

Signature of Non-Family Adult

Date

Thank you for your assistance! If there is anything you wish to discuss about the Lab Camp, please call Ann Wilson-Grant at 563-927-7489 or ann.wilsongrant@reqmedctr.org.

APPLICATION FOR PARTICIPATION

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Name (First & Last): _____ Date of Birth: _____

Address: _____

City, State, Zip Code: _____

Cell Phone: _____ *Email Address: _____

School: _____ Last Grade Completed: _____

Parent/Guardian Name & Relationship	Daytime Phone #

Emergency Contact (Other Than Parent): _____

Relationship to Student: _____ Daytime Phone #: _____

If the cost of camp would cause hardship, and you are interested in learning about tuition assistance, please check Yes. If not, please leave blank. Yes

Adult Shirt Size

X-Small Small Medium Large X-Large XX-Large

Permission Grant

I understand the risks involved in being exposed to disease while working in a healthcare facility. I understand training in Infection Prevention to protect volunteers, staff and patients/residents will be provided.

Permission is hereby granted to this applicant to participate in *Future Laboratory Professionals: Without the Lab, They're Only Guessing* at Regional Medical Center sponsored by the Administration of the hospital.

I understand to participate this applicant must be current on all immunizations and free of communicable disease. Verification of immunizations may be required.

I verify I will be available to attend *Future Laboratory Professionals: Without the Lab, They're Only Guessing* in its entirety.

Signature of Applicant

Date

Signature of Parent/Guardian

Date

* The email address listed is how students will receive correspondence about camp.

Marketing/Promotional Material Release Consent Form

Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone: _____

Email Address: _____

I hereby give my consent (by checking the boxes below):

to be photographed, videotaped, voice recorded, and/or interviewed for use by Regional Medical Center (RMC) for any and all marketing purposes including, but not limited to, printed/promotional materials, Electronic marketing (e.g. social media, website), newspaper, and radio.

that my true name be associated commercially with said material.

(for testimonials only) for Regional Medical Center staff, specifically _____
_____ may share general information regarding my endorsement.

In giving my consent, I waive any right to inspect or approve the use of the images or recordings or of any written copy. I also waive and release all current and future claims I may have against Regional Medical Center, arising from the use of an image or recording including, but not limited to claims of defamation, invasion of privacy, rights of publicity or copyright infringement, or any misuse, distortion, blurring, alteration or optical illusion that may appear in the finished product. Notwithstanding the foregoing, I reserve the right to revoke my consent in writing, which will be effective only upon receipt by the Marketing and Administrative Manager at RMC.

I hereby give my consent:

for myself as an individual over 18 years-of-age

Signature

Date

as a legal guardian, on behalf of minor under 18 years-of-age

Legal Guardian Signature

Date

Print Name

Relationship to patient

Internal Use Only:

Scanned

Confidentiality and Security Agreement

I understand that Regional Medical Center in which or for whom I work, volunteer, or provide services, has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of our patients' health information. Additionally, Regional Medical Center must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems, and management information (collectively, with patient identifiable health information, "Confidential Information").

In the course of my employment/assignment at Regional Medical Center, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my job-related duties in accordance with Regional Medical Center privacy and security policies, which are available in the individual departments, and (on the Intranet if applicable). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

I will not disclose or discuss any Confidential Information with others, including friends and family, who do not have a need to know it.

I will not in any way divulge, copy, release, sell, loan or destroy any Confidential Information except as properly authorized.

I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.

I will not make any unauthorized transmissions, inquires, modifications, or purging of Confidential Information.

I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with Regional Medical Center.

Upon termination I will immediately return any documents or media containing Confidential Information to Regional Medical Center.

I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with Regional Medical Center.

I will act in the best interest of Regional Medical Center and in accordance with its Code of Conduct at all times during my relationship with Regional Medical Center

I understand that violation of this Agreement may result in disciplinary action, up to and including termination of employment, suspension, and loss of privileges, and/or termination of authorization to work within Regional Medical Center, in accordance with Regional Medical Center's policies.

I will only access or use systems or devices that I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized users.

I understand that I should have no expectation of privacy when using Regional Medical Center's information systems. Regional Medical Center may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.

I will practice good workstation security measures such as locking up diskettes when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.

I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved standards.

I will:

- Use only my officially assigned User-ID and password.
- Use only approved licensed software.
- Use a device with virus protection software.

I will never:

- Share/disclose user-IDs or passwords.
- Use tools or techniques to break/exploit security measures.
- Connect to unauthorized networks through the systems or devices.

I will notify my Manager, appropriate Information Technology personnel, or Privacy and/or Security Officer, if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.

The following statements apply to physicians using Regional Medical Center systems containing patient identifiable health information.

I will only access software systems to review patient records when I am actively involved in that patient's care, or have that patient's consent to do so. By accessing a patient's record, I am affirmatively representing to Regional Medical Center at the time of each access that I have the requisite patient permission to do so, and Regional Medical Center may rely on that representation in granting such access to me.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Employee/Consultant/Volunteer/Student/Physician/Healthcare
Representative Signature

Date

Employee/Consultant/Volunteer/Student/Physician/Healthcare
Representative Printed Name