



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

DEPARTMENT OF
COMMUNITY HEALTH

STUDENT INTERN
PARTICIPATION
REQUIREMENTS

Purpose

The Department of Community Health (DCH) Intern Program is a valuable learning experience for college and university students in a healthcare or related career. The program is administered by the Office of Human Resources (OHR) and the length of the internship can range from a minimum of 6 weeks to a maximum of 13 weeks.

Eligibility Requirements

Students meeting the following requirements may be considered for an internship:

- He/she must be a currently enrolled sophomore, junior, senior, graduate student, or law student, or no more than one year past graduation.
- He/she must have a 2.75 GPA or higher on a 4.0 scale and be in good academic standing.
- Preference may be given to a Georgia resident or attending/attended a Georgia college, university, or graduate school.

Disqualification Standards

Students will be disqualified from participation in the DCH Intern Program for any of the following:

- Deliberate misrepresentation or falsification of any DCH application or background information.
- Deliberate misrepresentation or omission of illegal drug history (use, sale, distribution, or harvesting/manufacturing) in connection with disclosures.
- Prior convictions for a felony or misdemeanor of high and aggravated nature.

DCH Procedures

1. Interns will conform to the dress and conduct code of the DCH.
2. The supervisors of the work unit in which the intern works will be directly responsible for the intern while on site.
3. Interns will be exposed, as much as possible, to the various operations of the assigned work unit.

Summary Report

At the conclusion of the internship, the intern will provide a written evaluation of the field experience to the intern's DCH supervisor, emphasizing the strong and weak points of the experience and any recommendations for change. Copies of the above evaluations will be forwarded to the student's college or university and to the OHR intern coordinator for filing and for dissemination to appropriate supervisory personnel.

Exceptions

Exceptions to the above policy must be approved by the Office of Human Resources.

Responsibilities of Supervisor

1. Introduction to full range of work accomplished by unit; processes and procedures.
2. Completion of field placement requirements indicating:
 - Work responsibilities/expectations
 - Work hours
3. Intern Orientation
4. Training of work roles
5. Reading List for the student (Policies & Procedures)
6. Assignment of specific projects for intern
7. Evaluation of student performance
8. Monitoring of student work & notifying OHR intern coordinator if intern fails to complete work.

DEPARTMENT OF COMMUNITY HEALTH
STUDENT INTERN

STATEMENT OF COMMITMENT

GUIDELINES FOR DCH INTERNS

While an intern at the DCH, I, _____, a student at _____, will adhere to the following guidelines:

1. I will not divulge or disclose to anyone other than appropriate DCH personnel any information to which I might be exposed through my internship with the DCH. I understand that failure to follow the guidelines can lead to dismissal from the DCH intern program and/or other disciplinary or legal action.
2. I will follow the DCH policies and procedures related to the work unit to which I am assigned and as set forth by my supervisor.
3. I understand that all notes, papers and memoranda in any format concerning my internship must be reviewed by my DCH supervisor before any dissemination is made to my school or any instructor or person not an employee of the DCH.
4. During my internship, I will strive not to do anything in my personal life which would create a negative public perception of myself or the DCH.
5. I understand that during my internship I will be required to assist in administrative duties. I will ensure that all administrative work I undertake will be completed in a professional, proper and timely manner.
6. I understand that during my internship I am responsible to the DCH supervisor or his/her designee of the work unit to which I am assigned.
7. I understand that my internship can be terminated at any time without cause by a DCH supervisor.
8. I understand that I will be required to work an average of 20 to 40 hours a week during DCH's normal business hours. All duties required of me will be of a professional nature and supervised.

Signature of Intern

Date

This student is recommended by _____ to participate in the DCH intern program.
(College/University)

(Signature of College/University Official Approving Intern Application)

Signature of DCH Division Director

Date

Signature of DCH Human Resources Director

Date

Signature of DCH Chief Operating Officer

Date

DEPARTMENT OF COMMUNITY HEALTH INTERN PROGRAM

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION

I do hereby authorize a review and full disclosure of all records concerning me to any duly authorized agent of the Department of Community Health (DCH), whether such records are of a public, private, or confidential nature. I understand that the DCH may review all records concerning me at any time while I am being considered for or during my internship. Should I be offered employment with the DCH, I further understand that permission is granted to run additional background checks during my term of employment with the DCH without seeking additional consent from me.

The intent of this authorization is to give my consent for full and complete disclosure of all records of my driving history, criminal history, educational background, military personnel records, records of financial or credit institutions (including records of loans), records of commercial or retail credit agencies (including credit reports and/or rating), and any other financial statements and records wherever filed, employment and pre-employment records and records of local, state and federal criminal justice agencies.

I understand that any information obtained by a personal history background investigation which is based directly or indirectly, in whole or in part, upon this authorization will be used in determining my suitability for DCH internship, employment or employment in a governmental position of trust. I authorize the disclosure of the aforementioned personal information to any person(s) deemed by the DCH to be a participant in the determination process of such suitability. I also certify that any person(s) who may furnish such information concerning me shall not be held accountable for giving this information; and I do hereby release said person(s) from any and all liability which may be incurred as a result of furnishing such information.

A photocopy of this release form will be as valid as the original form, even though the photocopy does not contain my original signature.

I have read and fully understand the contents of this Authorization for Release of Personal Information Document.

_____	_____
Full Name Printed	Signature
_____	_____
Street Address	Sex
_____	_____
City/State	Date of Birth
_____	_____
Social Security Number	Date

CONFIDENTIALITY AGREEMENT FOR NON-EMPLOYEES

As an intern/volunteer with the Georgia Department of Community Health (“DCH”), and as a condition of my service, I acknowledge the following terms and am aware that I will be held accountable for my conduct in accordance with the following:

1. I understand that I am responsible for complying with the DCH Policies and Procedures related to privacy and security policies and procedures developed under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).
2. I will follow the highest ethical standards in the performance of my duties, in keeping with the DCH Statement of Ethics and the Ethics in Procurement Policy, which calls for me to safeguard sensitive information about vendors or potential vendors and not to show prejudice or favoritism toward vendors or potential vendors. Specifically, I will not share information with any person or entity that may result in an unfair advantage for any vendor in a DCH procurement.
3. I will treat all information received in the course of my service with DCH, which relates to the members of the health plans administered by DCH, including the Medicaid program, PeachCare for Kids and the State Health Benefit Plan, as confidential and protected health information.
4. I will use and disclose health plan member information only as necessary and appropriate to perform assigned tasks, consistent with DCH Policies and Procedures and under the direction of my DCH supervisor.
5. I will not use e-mail to transmit confidential and protected health information or sensitive information about health plan members or vendors unless I am authorized to do so under the DCH Policies and Procedures, which assure appropriate safeguards for the information, and at the request of my DCH supervisor.
6. Upon discontinuing my service with DCH, I agree to continue to maintain the confidentiality and privacy of any information I learned while I was at DCH, to provide or return all notes, documents and files, in any format, to the DCH supervisor and to return any keys, access cards, or any other device that would provide access to DCH or its information to the DCH supervisor.

Name (Print Above)

Date

Signature