Thank you for your interest in Central Maine Health Care Vascular Access Training Program. Before scheduling future nurses for training at our facility, a few things need to be completed prior to their arrival.

1. We will need to know how many nurses will require training. Please ask that they contact me directly with any questions or concerns at mcglaufw@cmhc.org. I will provide them with directions to the facility, where, and when to meet.
2. I have attached a letter of requirements, which the nurse training will need to complete prior to their arrival. The hospital has its regulatory requirements that we need for an outside RN to practice with us.
3. Training using ultrasound guidance for vascular access device insertion is 5 days (Monday – Friday).
4. We have found this needs to be a hard rule for the attendee to start to feel comfortable - for the preceptors to feel comfortable saying they feel comfortable signing any paperwork.
5. The nurses that are interested in attending will need to have completed any didactic training prior to arrival so as not spend several hours on how to turn the equipment on and what buttons do what. This will be a short review on the first day.
6. We will need a signed agreement or PO for training for reimbursement
7. Your attendee will need to have either a valid Maine Nursing license or their nurse licensing state must be a part of the enhanced Nursing Licensure compact. https://nurse.org/articles/enhanced-compact-multi-state-license-eNLC/
8. The number of procedures done cannot be guaranteed. Come ready to learn and open to all experiences.

Please contact me as soon as possible to schedule dates for training or if you have any questions or concerns.

Thank you,

Warren McGlauflin, RN, VA-BC
Vascular Access Specialty Team Nurse Leader
Central Maine Medical Center
300 Main St.
Lewiston, ME
04240
Phone: (207)795-7578
Fax: (207)330-7254
mcglaufw@cmhc.org

VASCULAR ACCESS TRAINING PROGRAM
DOCUMENTATION OF REQUIREMENTS

EXPECTATION:	TRAINEE	PICC TEAM
1. Resume or Curriculum Vitae		
2. RN license for the State of Maine or compact license		
3. PICC Education (didactic) Certificates of Completion (for PICC 101, 102 & 103) from Infusion Knowledge		
4. Background screening from a company of your choice *(including social security address/alias trace; state of residence criminal background search; national sex offender search; office of inspector general search; and excluded party list system search)*		
5. Documentation of immunizations or applicable waiver *(including MMR, Varicella, Hepatitis B, Tuberculin Test - either PPD skin test, T-SPOT, or QuantiFERON-TB Gold, annual influenza, and COVID-19)*		
6. Professional liability insurance *(minimum coverage of $1 million each claim and $3 million aggregate)*		
7. Signed acknowledgment page indicating review of the CMMC *Clinical Experience Student Informational Handbook*		
8. Signed acknowledgment page indicating review of the CMMC *Confidentiality of Patient Information and Other Information* policy		
9. Copy of your driverôs license		
10. Valid BLS certification card		
11. Signed *Participation Agreement or Waiver*		

I, _____, have read and understand that all of the above-required items must be submitted prior to my scheduled PICC and/or Midline training at Central Maine Health Care.

Trainee Signature: _____ **Date:** _____

PICC Team: _____ **Date Completed:** _____

MANDATORY VACCINE MEDICAL EXEMPTION FORM

Team Member Name:	Date of Birth:
Primary Phone:	Team Member E-mail:
Home Address:	

The State of Maine Department of Health and Human Services has established Immunization Requirements for Healthcare Workers (10-144 Code of Maine Rules, Chapter 264) as set forth in 22 MRSA §802. Vaccines included are: measles, mumps, rubella, varicella, Hepatitis B and influenza.
Medical contraindications and precautions for immunizations are based upon the most recent General Recommendations of the Advisory Committee on Immunization Practices (ACIP)/CDC. Available at https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html or https://redbook.solutions.aap.org/redbook.aspx

My patient is requesting a medical exemption from one of the following vaccines: influenza, measles, mumps, rubella, varicella requirement for the following reason:

Allergy

☐ A documented history of a severe allergic reaction to any component of an influenza, MMR, varicella vaccine or to a substance that is cross-reactive with a component. Please indicate which of the following vaccines are contraindicated and name the components, by vaccine.

List component causing allergy by vaccine:

Influenza _____

MMR _____

Varicella _____

☐ A documented history of a severe allergic reaction after a previous vaccine. Please indicate to which vaccine the patient had a reaction and the date of the vaccine & reaction.

List date and type of reaction by vaccine:

Influenza _____

MMR _____

Varicella _____

Physical Condition/ Medical Circumstance

☐ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with Influenza, MMR or Varicella.

Explanation:_____

_____

_____

_____

_____

Attestation

I am a physician (MD or DO) licensed to practice medicine in a jurisdiction of the United States or a Nurse Practitioner or Physician Assistant licensed in a jurisdiction of the United States.

By signing below, I affirm that I have reviewed the current CDC/ACIP Contraindications or Precautions and affirm that any contraindication(s)/precaution(s) is enumerated by the CDC/ACIP and consistent with established national standards for vaccination practices. I understand that I might be required to submit supporting medical documentation.

PLEASE PRINT:

Healthcare Provider Name: _____

NPI #: _____ License #: _____ State of Licensure _____

Phone: _____ Fax: _____ E-mail: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Signature: _____ Date: _____

Revised 10.3.2023

VASCULAR ACCESS TRAINING PROGRAM
PARTICIPATION AGREEMENT & WAIVER

I _____ ("Participant"), for the sole consideration, the sufficiency of which is hereby acknowledged, of the right to participate in the event or program described as the Vascular Access Training Program (the "Program") at Central Maine Medical Center ("Hospital"), do hereby agree to the following relating to the Program.

Training Program.

a) *Program.* Hospital will provide hands on vascular access training using guided vascular access devices (venous and arterial) utilized by the Vascular Access Specialty Team at Central Maine Medical Center.

b) *Duration.* Vascular Access Device training utilizing ultrasound shall occur over the course of at least five (5) days. If more days are desired it will be in 1 day increments at the agreed upon cost listed in this agreement per day.

Fees.

a) For training provided by Hospital, Participant shall pay Hospital Two Thousand Five Hundred Dollars ($2,500) per Clinical Staff per training, further desired days training will be at a cost of $500 per day. Participant shall pay Hospital for such training prior to commencement of the Program.

b) Additional costs that may be incurred as part of participation, including but not limited to, food, travel and lodging are the responsibility of Participant.

Required Documentation. Prior to commencement of the Program, Participant must provide Hospital with proof of the following:

a) copy of a valid Maine clinical License or valid compact nursing license.
b) In compliance with Joint Commission Standards and Hospital Policy, documentation of Participant's passing the appropriate background screenings that include the following searches:
    i. Social Security Address/ Alias Trace;
    ii. State of residence criminal background search;
    iii. National sex offender search;
    iv. Office of Inspector General search; and
    v. Excluded Party List System search.
c) Proof of immunizations as required by *State of Maine Immunization Requirements for Healthcare Workers* (10-144 CMR Ch. 264).

Insurance. Participant shall be responsible for procuring liability insurance for itself and its faculty, employees, agents and other representatives at its expense. The limits of each policy shall be a minimum of $1,000,000.00 per claim and $3,000,000.00 aggregate. Participant shall provide to Hospital a current certificate of insurance prior to commencement of the Program. Such insurance coverage in no way limits Participant's liability with regard to its own errors, negligence or omission.

Compliance with Laws. Participant shall observe and comply with the Federal and State laws, rules, regulations, policies and procedures applicable to the Program.

Removal of Non-Compliant Participant. Hospital shall have the authority to remove any Participant who fails to comply with Hospital policies and procedures or other requirements. If Hospital deems Participant is in any way a danger to patients, staff, the general public, or themselves, Hospital may expel Participant immediately.

Waiver. In exchange for being allowed to participate in the Program, I hereby release and forever discharge and agree to indemnify Hospital, its officers, agents and employees from any and all claims, demands, rights, expenses, actions, and causes of action, of whatever kind, arising from or by reason of any personal injury, bodily injury, property damage, or the consequences thereof, whether foreseeable or not, resulting from or in any way connected with my participation in the Program. I further covenant and agree that for the consideration stated above, I will hold forever harmless and will not take legal action against Hospital and its officers, agents, and employees for any claim for damages arising or growing out of my participation in the Program whether caused by negligence or otherwise.

I acknowledge and represent that I freely and voluntarily sign this Agreement.

Printed Name: _____

Signature: _____ Date: _____