UP HEALTH SYSTEM
BELL

Student Forms

REQUIRED FORMS

- ✓ Confidentiality and Security
- ✓ Confidentiality and Hold Harmless
- ✓ Policy Acknowledgement
- ✓ HIPAA Acknowledgement (Student)
- ✓ Code of Conduct Acknowledgement
- ✓ Emergency Contacts

Student Name: _____

Start Date: _____

End Date: _____

School/Program: _____

Viewed/Received:

- ✓ Map
- ✓ Policy access
- ✓ HIPAA information
- ✓ Hospital Code Listing
- ✓ Orientation Guide
- ✓ Code of Conduct booklet

I have received and/or viewed the information listed above.

_____ _____

Signature **Date**

Confidentiality and Security Agreement

I understand that the facility or business entity named below (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with individually identifiable health information and protected health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will not use company systems to access patient information if it is not necessary to perform my job related duties. This includes NOT accessing my own health information or that of my child or person's for which I am personal representative via the company systems. The Company's Privacy and Security Policies available on the Company intranet (on the Security Page) and the internet (under Ethics & Compliance). I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation, even if the patient's name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purgings of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Code of Conduct at all times during my relationship with the Company.
9. 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 the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company 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.
12. I will practice good workstation security measures such as locking up electronic media devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
    a. Use only my officially assigned User-ID and password (and/or token (e.g., SecurID card)).
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
15. I will never:
    d. Share/disclose user-IDs, passwords or tokens.
    e. Use tools or techniques to break/exploit security measures.
    f. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Local Security Coordinator (LSC), or appropriate Information Services person 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 any Company systems containing patient identifiable health information (e.g. HMS, Meditech, eCW):

17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.
18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information.
19. I have no intention of varying the volume or value of referrals I make to the Company in exchange for Internet access service or for access to any other Company information.
20. I have not agreed, in writing or otherwise, to accept Internet access in exchange for the referral to the Company of any patients or other business.
21. I understand that the Company may decide at any time without notice to no longer provide access to any systems to physicians on the medical staff unless other contracts or agreements state otherwise. I understand that if I am no longer a member of the facility's medical staff, I may no longer use the facility's equipment to access the Internet.

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/Vendor/Office Staff/Physician Signature	Facility Name and COID 16950	Date
Employee/Consultant/Vendor/Office Staff/Physician Printed Name	Business Entity Name Bell Hospital	

UP HEALTH SYSTEM
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Confidentiality Statement and Hold Harmless Agreement

I, the undersigned, agree to abide by all rules and requirements requested and to conduct myself in an appropriate manner.

I understand that in the course of my time at Bell, I may have incidental exposure to confidential information. Confidential information means all patient, employee, and student information. I will maintain the confidentiality of this information at all times. I agree not to disclose the confidential information in any way or in any form.

I understand that there are certain risks inherent to and associated with the activities of any facility in which patient care are conducted. I agree to the assumption of those risks and to not hold Bell Hospital/Bell Medical or its board members, or employees responsible for any harm or injury, from any cause, which may befall me related to or arising out of participation in the program, and hereby release said entities and persons from any liability relating thereto. I further agree to indemnify and hold said entities and person harmless from the claims or causes of action asserted by any other person on my behalf, or in their own right, arising out of said participation. I similarly agree to hold said entities and persons harmless from the claims of other persons arising out of any acts done by me. I 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 Michigan law; and any such criminal conduct or intentional tort is against Bell Hospital/Bell Medical's policy and therefore outside the scope of the person's employment or relationship with Bell Hospital/Bell Medical for which Bell Hospital/Bell Medical is not liable. I agree that these conditions and agreements are binding on all of my heirs, executors, administrators, representatives, assignees and successors in action.

I have read and understand the above and willingly agree to said terms and conditions.

Signature:_____ Date:_____

Printed Name:_____

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PERSONNEL POLICIES ACKNOWLEDGEMENT FORM

I have received information on how to access the UP Health System - Bell Personnel Policies on the Company intranet ***hawking*** and on PolicyStat. I acknowledge that I am required to read the policies and abide by the principles of their content. I understand that if I have any questions regarding the policies I can contact my immediate supervisor or the Human Resources Department. I understand I am responsible for reviewing updated policies either in my department manual or by accessing them on-line.

_____ _____

Employee Signature Date

_____

Employee Name (please print)

UP HEALTH SYSTEM
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HIPAA TRAINING: CONFIDENTIALITY AND PROTECTION OF PATIENT INFORMATION
ACKNOWLEDGEMENT FORM FOR STUDENTS

I have received a copy of the Bell Hospital/Bell Medical HIPAA Training: Confidentiality and Protection of Patient Information. I acknowledge that I am required to read the policy and abide by the principles of its content. I understand that if I have any questions regarding HIPAA, I can contact my preceptor, Bell's Compliance Officer or the Human Resources Department.

I understand during my time as a student at Bell, that I am exposed to confidential information regarding patients, members of patients' families, businesses and systems information, and information about Bell employees. I understand that I am obliged to maintain the confidentiality of such information at all times.

I acknowledge that I may share such information only with employees who have need of that information in order to perform their jobs. I understand that when the need to share information arises, I must do so in a manner to protect the confidentiality of the information.

I understand that a HIPAA violation and any breach of confidentiality is serious that I may be subject to legal action.

_____ _____
Signature Date

_____
Name (please print)

_____
Witness

Acknowledgment

I acknowledge that I have received LifePoint's' Code of Conduct. I understand that it fosters a culture of learning and safety and that it represents mandatory policies of the organization, and I agree to abide by it.

Signature _____

Position _____

Printed Name _____

Date _____

Facility _____

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NAME:_____

HOME ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE NUMBERS: Home:_____Cell:_____

EMERGENCY CONTACT INFORMATION

PRIMARY CONTACT: _____ Relationship:_____

PRIMARY ADDRESS: _____

Cell:_____ Home:_____

Work:_____

SECONDARY CONTACT: _____Relationship:_____

SECONDARY ADDRESS: _____

Cell:_____ Home Phone:_____

Work:_____

ADDITIONAL INFORMATION THAT MAY BE HELPFUL IN THE EVENT OF AN EMERGENCY:

_____

In case of accident or illness during internship or clinical rotation at Bell, should I be unable to consent to treatment, I HEREBY AUTHORIZE THE SITE SUPERVISOR TO SECURE MEDICAL TREATMENT FOR AN ACUTE EMERGENCY from an emergency service included but not limited to emergency services of UPHS Bell.

Signature:_____ Date:_____

MINOR EMERGENCY AUTHORIZATION PERMIT

In case of accident during Internship or clinical rotation at Bell, I request to be contacted. Should I be unavailable, I HEREBY AUTHORIZE THE SITE SUPERVISOR TO SECURE MEDICAL TREATMENT FOR AN ACUTE EMERGENCY from an emergency service included but not limited to emergency services of UPHS Bell. I understand that should a health emergency arise, I will be notified, but that if I cannot be reached by telephone, such medical treatment deemed necessary by competent medical personnel is authorized and will be paid for by myself or my insurance company.

Parent or Guardian Signature: _____Date:_____