

# Student Forms Packet

for

## Job Shadow: *Less than 12 hours*

Please complete the following forms and return to your Student Placement Coordinator.

- A. Student Profile
- B. Consent to Liability form (if applicable)
- C. Confidentiality Agreement
- D. HIPAA Agreement

### Student Profile / Identification

*Incomplete packets will be returned*

Name (First, Middle Initial, Last): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Currently employed by Intermountain Healthcare?  Yes  No

If yes, employee number (if known): \_\_\_\_\_

Previous name(s) if any: \_\_\_\_\_

E-mail: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Permanent Address: Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Address while at School: Street: \_\_\_\_\_  
(if different from above) City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Major: \_\_\_\_\_

Course Number: \_\_\_\_\_ School Instructor: \_\_\_\_\_

Hospital/Unit: \_\_\_\_\_ From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**NOTE:** Upon completion of this profile you will be provided a student ID sticker badge. Your supervisor must remove the sticker badge after your one-day observation is complete.

# Consent to Liability

*for students under 18 years of age or still in high school*

I, \_\_\_\_\_ (Parent), as legal guardian for \_\_\_\_\_ (Child), intending to be legally bound for myself and my heirs, assigns or personal representative, agree to the following in connection with the \_\_\_\_\_ (school Program), at \_\_\_\_\_ (Facility), a division of IHC Health Services Inc, (IHCHS):

1. I consent to my Child attending and participating in the Program at the Facility.
2. I agree to indemnify and save harmless, IHCHS their officers, agents and employees from and against any and all loss, damages, injury or death, damages to personal property, howsoever caused, resulting directly or indirectly from my Child's participation in the Program at the Facility.
3. I acknowledge IHCHS has not made any statement, representation or promise to me regarding any fact relied upon by me in entering into or executing this Consent to Liability and I specifically have not relied upon any statement, representation or promise of Hospital in entering into or executing this Consent to Liability.
4. I have carefully read this document and fully understand its contents and that it is a binding legal document.
5. My Child and I have carefully read and have discussed the attached Access and Confidentiality Agreement and we both fully understand its contents and understand it is a binding legal document.
6. I understand that my Child will not be permitted to participate in the Program if this Consent to Liability and the attached Access and Confidentiality Agreement, and HIPAA Agreement are not signed and returned to Child's advisor by \_\_\_\_\_, 200\_\_\_\_.

IN WITNESS WHEREOF, I have executed this Consent to Liability this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Parent's Printed Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State and Zip Code

\_\_\_\_\_  
Phone Number





Intermountain  
Healthcare

# ACCESS and CONFIDENTIALITY Agreement

(Workforce Agreement. Select One:  Employee;  Volunteer;  Student;  Other (specify: \_\_\_\_\_))

## BACKGROUND

- 1.0 **Purpose of This Agreement.** This Agreement explains your duties as a member of Intermountain’s Workforce regarding Confidential Information. Federal and state laws, as well as Intermountain Healthcare policies, protect Confidential Information. Those laws and policies assure that Confidential Information, which is sensitive and valuable, remains confidential. They also permit you to use Confidential Information only as necessary to accomplish legitimate and approved purposes.
- 2.0 **Confidential Information.** “Confidential Information” means data proprietary to Intermountain, other companies, or other persons, plus any other information that is private and sensitive and which Intermountain has a duty to protect. You may learn of or have access to some or all of this Confidential Information through oral communications, paper documents, Intermountain’s computer systems, or through your activities at or with Intermountain. Confidential Information includes, but is not limited to, information relating to the following:
  - A. Patients (e.g., medical records, conversations, admittance information, patient financial information, etc.);
  - B. Employees (e.g., salaries, employment records, disciplinary actions, etc.);
  - C. Intermountain’s business (e.g., financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.); and
  - D. Third-party information (e.g., computer programs, client and vendor proprietary information, source code, proprietary technology, etc.).

## AGREEMENT

- 1.0 **My Duties.** To qualify to access or use Confidential Information, I agree to comply with the laws and Intermountain Healthcare policies governing Confidential Information. My principle duties regarding Confidential Information include, but are not limited to, the following. By signing this Agreement I promise to:
  - A. Safeguard the privacy and security of Confidential Information;
  - B. Use Confidential Information only as needed to perform my legitimate responsibilities as a member of Intermountain Healthcare’s Workforce. This means, among other things, I will not:
    - (1) Access Confidential Information for which I have no legitimate need to know;
    - (2) Divulge, copy, release, sell, loan, revise, alter, or destroy any Confidential Information except as properly authorized within the scope of my responsibilities as a member of Intermountain’s Workforce; or
    - (3) Misuse Confidential Information;
  - C. Safeguard, and not disclose, my access code or any other authorization that allows me to access Confidential Information. This means, among other things, I will:
    - (1) Accept responsibility for all activities undertaken using my access code and other authorization; and
    - (2) Report any suspicion or knowledge I have that my access code, authorization, or any Confidential Information has been misused or disclosed without Intermountain’s permission. (I will report to my supervisor, my facility compliance coordinator, or to the Intermountain Compliance Hotline at 1-800-442-4845.);
  - D. Report activities by any individual or entity that I suspect may compromise the confidentiality of Confidential Information. (Reports made in good faith about suspect activities, as well as the names of the individuals reporting the activities, will be held in confidence to the extent permitted by law.);
  - E. Not use or share Confidential Information after termination of my Intermountain Workforce status; and
  - F. Claim no right or ownership interest in any Confidential Information referred to in this Agreement.
- 2.0 **Violation of Duty – Change of Status.** I agree that:
  - A. I am responsible for my noncompliance with this Agreement;
  - B. If I violate any provision of this Agreement, I will be subject to discipline, including but not limited to, dismissal as a member of Intermountain’s Workforce, loss of employment with Intermountain Healthcare, termination of my ability to access Confidential Information, legal liability.
  - C. Any violation by me of any provision of this Agreement, either while I am employed or after I am employed, will cause irreparable injury Intermountain that would not be adequately compensable in monetary damages alone or through other legal remedies, and will entitle Intermountain to preliminary and permanent injunctive relief, a temporary restraining order, and other equitable relief in addition to damages and other legal remedies; and
  - D. Intermountain may terminate my access to Confidential Information if my Intermountain Workforce status changes, Intermountain determines that to be in the best interests of Intermountain’s mission, or I violate any provision of this Agreement.
- 3.0 **Continuing Obligations.** I understand that my obligations under this Agreement will continue after termination of my Intermountain Workforce status.

Name: \_\_\_\_\_  
(Printed)

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Dept/Facility: \_\_\_\_\_

# HIPAA Agreement

## Education on Intermountain Healthcare's Privacy Practices

### A Guide for Students Receiving Training at an Intermountain Healthcare Facility

Protecting patients' privacy has always been an ethical requirement at Intermountain Healthcare. As of April 14, 2003, it is now a federal mandate that medical providers and hospital staff do so. As a student in Intermountain Healthcare's facilities, we require that you abide by our privacy practices. If you have questions about Intermountain Healthcare's privacy practices, please contact your instructor or Intermountain Healthcare's Corporate Compliance Hotline at 1.800.442.4845.

#### Handling Protected Health Information

Protected Health Information includes all medical, billing, and payment records that identify patients. Paper records, electronic records, and oral communication can all contain protected health information. Failure to properly protect patient information may result in:

- Verbal or written warnings
- Suspension or expulsion from your educational institution
- Legal liability for yourself, your educational institution, and/or Intermountain Healthcare

#### We Do

- Follow Intermountain Healthcare procedures for the release of protected health information.
- Limit the sharing of protected health information by taking precautions such as not having conversations about a patient in a hallway or other public area.
- Keep medical, billing, and payment records in secure areas.
- Ask questions when we are not sure if it is appropriate to release information.

#### We Don't

- Share patient information unless it is for legitimate business or patient care purposes.
- Share more health information than is appropriate for the situation.
- Share passwords.
- Use data that identifies a specific patient in a presentation.

### Patients' Rights

Federal regulations define specific patient rights.

#### We Do

- Provide each patient with Intermountain Healthcare's Notice of Privacy Practices that explains how we may use and share protected health information and the patient's rights.
- Allow patients to inspect and obtain a copy of their health information as permitted by law.
- Allow patients/ to request additions or corrections to their health information.
- Track occasions when we share protected health information outside of Intermountain Healthcare for certain purposes and provide a list of these disclosures to a patient on request.
- Provide a patient with the contact information for Intermountain Healthcare's Privacy Office and/or the U.S. Department of Health and Human Services when an individual wishes to file a complaint.

#### We Don't

- Take action against a patient who files a complaint with us or the U.S. Department of Health and Human Services.



_____	_____
Student Name (printed)	Signature
_____	_____
Date Reviewed	School Affiliation