

Emory Healthcare
HIPAA Confidentiality and Non-Disclosure Statement

I, _____, who will be participating as an unpaid inter in the department of _____, am aware of the Hospital's Regulations and Policies that are issued under the Health Insurance Portability and Accountability Act of 1996 (also known as the HIPAA Privacy Rule).

- ☐ I understand that all patient information, including medical records, other medical information, billing and financial data, is confidential.
- ☐ I agree to keep all patient information confidential.
- ☐ I agree to comply with all Hospital Privacy Policies and Procedures including those implementing the HIPAA Privacy Rule.
- ☐ I understand that if I violate patient confidentiality by using or disclosing patient information improperly, I may be subject to disciplinary action including having my Internship immediately terminated.
- ☐ I understand that if I have any questions or concerns about the Privacy Rule and/or the proper use or disclosure of patient information, I shall ask my supervising attending, the Hospital Privacy Officer, or the Hospital Compliance Officer.
- ☐ I understand and agree that the Hospital Privacy Policies and Procedures will apply to all patient information even after my Internships has been completed.
- ☐ I certify that I have read Emory's HIPAA Policy Regarding Confidentiality of PHI and reviewed the HIPAA PowerPoint presentation.
- ☐ I understand that no information about any patients I may observe or hear discussed while on the Internship or at any time thereafter may be transmitted to any third party or person (except other members of the clinical team caring for the patient) via text message, posting on any social network or another online site, or via any other written or verbal communication.

(Print) Observer Name

Signature

Date

**Emory Healthcare
Health Screen Form**

Observer Name _____

1. M.M.R. (Measles, Mumps, Rubella) if given instead of individual immunizations.
Born after 1957 – must have proof of two doses Measles, one dose Rubella and one dose Mumps _____
Born before 1957 – must have proof of one dose of MMR or positive titers to Rubella and Rubeola, or evidence of immunity by Rubella and Rubeola immune titers _____
2. Tuberculosis- Bacillus Calmette–Guérin (BCG), T-SPOT. *TB*, or purified protein derivative (PPD) shot(s) – TB test must have been given within 1 year.
Tuberculin skin test: Positive _____ Negative _____
If positive, have you had a chest x-ray? Neg. _____ Pos. _____
Been treated with Anti-tubercular Drugs? Yes _____ No _____
3. Varicella (Chickenpox)
Had disease or positive immune titer _____
Have not had disease _____
Have had vaccine _____
Have not had vaccine _____
4. Hepatitis B Vaccine
Had disease or positive immune titer _____
Have not had disease _____
Have had vaccine _____
Have not had vaccine _____
5. Current Season Flu Vaccine
Date of Shot _____

I certify that the above information is correct and that proof of the above can and will be provided upon request.

(Print) Observer Name

Signature

Date

Emory Healthcare Infection Checklist

Observer Name _____

1. Have you been around anyone with any of the following diseases within the past 30 days?

Chicken pox	Yes _____	No _____
Measles	Yes _____	No _____
German Measles (Rubella)	Yes _____	No _____
Mumps	Yes _____	No _____
Influenza	Yes _____	No _____

2. Have you had the following symptoms in the past 72 hours?

Fever	Yes _____	No _____
Conjunctivitis/Pink eye	Yes _____	No _____
Vomiting	Yes _____	No _____
Diarrhea	Yes _____	No _____
Cough	Yes _____	No _____
Congestion/Runny nose/Cold	Yes _____	No _____
Skin Sores	Yes _____	No _____
Rash	Yes _____	No _____

3. Have you had any chronic cough (lasting greater than 3 weeks), night sweats, unexplained fevers, loss of appetite, sudden weight loss, blood tinged secretions from the nose or mouth or coughed up? Yes _____ No _____

If any of the above are answered yes, the individual will not be allowed to participate in the internship, shadow, or rotation.

I certify that the above information is correct.

(Print) Observer Name

Signature

Date

**Emory University Unpaid Internship Program
Supervision Agreement of Intern**

I, the undersigned, agree to be responsible for supervising _____ while he/she participates in internship in the activities of the _____ clinical services during the period of _____ to _____. I acknowledge that _____ will be under my supervision, or the supervision of a team lead and that he/she is not to be present in any patient care area without supervision. I agree to ensure that intern _____ shall not participate in any patient care activities within Emory Healthcare, which includes touching patients, writing on the medical record, advising other care providers, patients or visitors, and scrubbing in the Operating Room. I also understand that he/she is not covered by Emory's Liability Program to provide patient care activities.

Sponsor Name and Title (print)

Signature

Date

Emory Healthcare
Release and Waiver of Liability

I, _____, wish to participate in the unpaid internship program and observe the activities of the _____ clinical service at Emory Healthcare from _____ to _____ in furtherance of my personal, educational goals.

I understand that I will not be allowed to perform any clinical activities or other work, to include the touching of any patient, documenting on any medical record, scrubbing in the OR, and advising of care providers or patients. I further understand that I will be under the supervision of _____.

I understand I am not to be involved in the provision of patient care or in a patient care area without my assigned sponsor being present with me.

I understand that if I breach this agreement, it will result in immediate termination of my internship.

I understand that even though I will only be observing or assisting in _____ clinical services I may be exposed to certain risk of bodily injury and other dangers, including but not limited to, exposure to blood borne pathogens, biological waste, and dangerous chemicals. I am aware of these risks and voluntarily assume these risks.

For and in consideration of Emory Healthcare, allowing me to observe the activities of the _____ clinical services to further my educational goals, I hereby release and forever discharge Emory Healthcare and it's officers, agents and employees from all claims, demands, rights and causes of action of whatever kind or nature arising from and by reason of any and all known and unknown, foreseen and unforeseen bodily and personal injuries, death, or damage to property arising out of my observation activities, including but not limited to, those specific risks enumerated above. In addition, I understand and take sole responsibility for any personal belongings I bring with me to Emory.

I have read this document carefully and I voluntarily choose to participate in the activities described herein. I hereby certify that I am at least 18 years of age, I am legally competent, and I am signing this document with full knowledge of its significance.

(Print) Observer Name	Signature	Date
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(Print) Witness Name	Signature	Date
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Emory Healthcare Internship Code of Conduct¹

When shadowing a medical staff member, I will...

- Arrive promptly
- Accurately represent my position and role
- Appreciate the limits of my role as an observer
- Ensure patients give informed consent for shadowing freely and without undue influence
- Respect patients' right to refuse to have visitors present
- Treat all patients and staff with respect and dignity, regardless of age, gender, race, ethnicity, national origin, religion, disability, or sexual orientation
- Maintain strict confidentiality about patient information
- Maintain honesty and integrity by being forthright in my interactions with patients, peers, physician supervisors, and staff
- Ensure patient safety by remaining at home if I am ill
- Report concerns about patient safety to the appropriate individual
- Behave in an appropriate, professional, courteous manner at all times
- Not initiate or accept patients' invitations to engage in social relationships
- Dress and act professionally
- Not abuse drugs or alcohol
- Be aware of and follow the guidelines of my sponsoring institution

I agree to follow the Code of Conduct described above and to adhere to Emory Healthcare's Pledge, attached hereto:

(Print) Observer Name

Signature

Date

¹ Kitsis, E., Goldslammer, M. (2013). Physician Shadowing: A Review of the Literature and Proposal for Guidelines. *Academic Medicine*, Vol. 88, No.1, pg.4.



Attestation of Annual Regulatory Requirements

For non-EHC Supplemental Personnel:

Nursing/Clinical/Research Ancillary Staff credentialed by the Nursing Office of Credentialing
Visiting Scholars/Students/Clinicians for Observation Only authorization
Contractors Community Staff Emory University Employees Vendors Students

Instructions:

Courses in PDF format for self-study. **Highlight link, choose drop down "Open hyperlink":**

<http://www.ouehc.org/departments/human-resources/organizational-development/learning-management-system-services-hlc/non-ehc-staff-resources.html>

If hyperlink does not open: Emory Intranet site > Depts & Groups > Human Resources > Organizational Development > Learning Management System > Non-EHC Staff Resources.

- Read and initial each of the regulatory requirement areas below. (there are no on-line tests for completion)
- Return initialed and signed attestation to the credentialing office. (this is an annual requirement)

(Required)

Initials

- | | |
|---|-------|
| 1. Back Safety | _____ |
| 2. Corporate Compliance | _____ |
| 3. Electrical Safety | _____ |
| 4. Emergency Preparedness | _____ |
| 5. Hazard Communications | _____ |
| 6. Life Safety | _____ |
| 7. Patient Safety | _____ |
| 8. Privacy and Security | _____ |
| 9. Standard Precautions | _____ |
| 10. Workplace Safety | _____ |
| 11. Unified Emergency Codes | _____ |
| http://www.ouehc.org/departments/safety/EM/codecard.html | _____ |

(Optional)

- | | |
|--|-------|
| 12. Additional Infection Control (for Mid-Level Service Providers) | _____ |
| 13. Appropriate Care for the Adult Patient | _____ |
| 14. Appropriate Care of the Pediatric Patient (optional) | _____ |

I, (please print name) _____,
acknowledge that I have read and understand each EHC Annual Regulatory Requirement as a
condition to maintain my credentialing authorizations.

SIGNATURE _____ Initials: _____ Date _____

Emory Healthcare System Pledge



Our Pledge

We will treat each other the way we want to be treated.

We will...

- treat everyone as professionals and with respect and dignity
- greet each other by name
- welcome and encourage new team members
- be honest and open in all interactions
- be respectful of everyone's privacy
- be culturally and racially sensitive

We will not...

- raise our voices in anger or use sarcasm or profanity
- be passive-aggressive
- make culturally or racially derogatory remarks
- undermine each other's work
- criticize each other and Emory in public spaces

We will cultivate a spirit of inquiry.

We will...

- ask "why" when we have questions or concerns, especially about safety
- ask for a pause when we think someone is about to make a mistake or do something unsafe
- thank each other for raising concerns
- declare our openness to the inquiry of others

We will not ...

- respond with anger or sarcasm when someone requests a pause
- intentionally belittle or respond in a threatening or condescending manner when someone asks a question
- tolerate rudeness
- stifle learning

We will defer to each other's expertise.

We will...

- encourage each other to offer different perspectives
- recognize that all members make important contributions to the team
- seek help when we don't know the answer

We will not ...

- belittle or ignore the ideas and perspectives offered by each other
- assume that expertise is overruled by age, profession, or rank

We will communicate effectively.

We will...

- listen thoughtfully and ask for clarification when we don't understand
- check that others have understood when we say something important
- remain respectful with our body language and tone of voice
- remain calm when confronted with or responding to stressful situations
- use scripts, read-back, repeat-back, or other techniques where appropriate to reduce the chance of misunderstanding

We will not ...

- stifle clarifying questions
- interrupt our team members unnecessarily
- say "it's not my job" or "it's not my responsibility"

We will commit to these behaviors in support of Emory Healthcare Care Transformation

We will...

- encourage and support each other
- hold each other accountable for the behaviors identified in this Pledge

Emory Healthcare HLC Learning Modules

The following online modules must be completed prior to an individual's start date. Access and instructions for these modules shall be granted once the Observership Request Form has been received by Emory Healthcare.

- **JOBSK: EHC Corporate Compliance FY13-6143**

Estimated Course Length: 60 minutes

This course provides an overview of the Emory Healthcare Corporate Compliance Program. This course is part of your employee commitments. Employee commitments help us keep our promise to our patients: impeccable clinical outcomes, patient safety, and patient satisfaction.

- **JOBSK: EHC Emergency Preparedness FY13 - 6145**

Estimated Course Length: 45 minutes

This course reviews information and plans to respond to emergencies and disasters including an Emergency Response Plan and the National Incident Management System (NIMS). This course is part of your employee commitments. Employee commitments help us keep our promise to our patients: impeccable clinical outcomes, patient safety, and patient satisfaction.

- **JOBSK: EHC Patient Safety FY13 - 6148**

Estimated Course Length: 120 minutes

This course reviews the Patient Safety Program of Emory Healthcare including the National Patient Safety Goals of The Joint Commission. This course is part of your employee commitments. Employee commitments help us keep our promise to our patients: impeccable clinical outcomes, patient safety, and patient satisfaction.

- **JOBSK: EHC Privacy and Security FY13 - 6149**

Estimated Course Length: 31 minutes

This course provides an overview of the Emory Healthcare patient privacy and electronic information security practices. This course is part of your employee commitments. Employee commitments help us keep our promise to our patients: impeccable clinical outcomes, patient safety, and patient satisfaction.

- **JOBSK: EHC Standard Precautions FY13 - 6150**

Estimated Course Length: 45 minutes

This course provides essential information, policies, and procedures on safe work practices, known as "standard precautions," when working with blood and body fluids, or around possible airborne pathogens. This course is part of your employee commitments. Employee commitments help us keep our promise to our patients: impeccable clinical outcomes, patient safety, and patient satisfaction.

- **JOBSK: EHC Workplace Safety FY13 - 6151**

Estimated Course Length: 60 minutes

This course describes how to prevent and handle sexual harassment and workplace violence. This course is part of your employee commitments. Employee commitments help us keep our promise to our patients: impeccable clinical outcomes, patient safety, and patient satisfaction.

ATTENTION EUPD — Return results to: Name _____ Location: ☐ EU ☐ EUH ☐ CLH Phone _____
Date sent to EUPD _____ Department _____

EMORY

CONSENT TO PERSONAL RECORDS/HISTORY RELEASE

I hereby authorize Emory University Police Department or other designated agency to receive any criminal history record information pertaining to me which may be in the files of any state or local criminal justice agency in Georgia. I further authorize the hiring agent(s) of Emory to receive this information for the purpose of employment consideration.

Full Name _____
Last First Middle Alias/Other
Address _____ Apt. _____
City _____ State _____ Zip _____

If you have not been a Georgia resident during the last 6 months, please provide former address below:

Former Address _____ How long? _____
City _____ State _____ Zip _____

Date of Birth _____ Social Security Number _____

Place of Birth _____
City County State/Province Country

Driver's License Number _____ State of Issue _____

Sex: ☐ Male ☐ Female Race: ☐ Black ☐ Asian ☐ Native American
☐ White ☐ Hispanic ☐ Other (specify) _____

Physical Description: Height _____ Weight _____ Eye Color _____

INSTRUCTIONS -- Please Read

Read the following carefully and answer truthfully. If you have been convicted of a crime, you may not be automatically disqualified from consideration for employment. **GIVING FALSE OR INCOMPLETE INFORMATION IS SUFFICIENT CAUSE TO DISQUALIFY YOU FROM EMPLOYMENT.** If you are not sure of the court disposition of a case, list all other information requested.

Have you EVER been convicted of a crime, paid a fine, forfeited a bond, been sentenced (by a judge) to perform community service, pled nolo contendere (no contest), pled guilty, been given a suspended sentence, or been sentenced to jail or prison time? (Include DUIs, but DO NOT include minor traffic offenses, juvenile cases, cases sealed or expunged by a court, or cases completed under the First Offender Act.)

DO NOT ASSUME CHARGES OR CONVICTIONS HAVE BEEN REMOVED.

If the answer is YES to any of the above, list all information requested below. (Please use additional sheets if necessary.)
If none of the above apply to you, simply write "NONE."

<u>Charge/Offense</u>	<u>Date</u>	<u>Arresting Agency/Location</u>	<u>Court Disposition</u>

Having read all of this form, I give Emory my consent to conduct the investigation into my background described above and release all persons from any and all liability with respect to said investigation.

Signature _____ Date _____

Notary Public _____ My commission expires _____

IF NOTARY IS NOT AVAILABLE, WE WILL ACCEPT A LEGIBLE COPY OF YOUR DRIVER'S LICENSE, PASSPORT, OR GOVERNMENT ISSUED I.D. THE FOLLOWING "I.D." CARDS ARE NOT ACCEPTABLE: SCHOOL I.D., EMPLOYER I.D., AND PRIVATE ISSUED I.D.

DO NOT WRITE IN THIS SPACE — For HR Use Only

- ☐ No record on file
☐ Record matches applicant information

DISCREPANCY (Forwarded to Detectives):

- ☐ Possible outstanding warrant ☐ Required information omitted
☐ Indeterminate. Fingerprinting may be required ☐ Other

Report completed by _____ Date _____