STUDENT OBSERVATION

RELEASE AND INDEMNITY AGREEMENT

**The undersigned,** Click here to enter text.**, agrees to participate only as an observation student at Brooks Rehabilitation.**

**In consideration of permitting the above party to participate as an observation student, I hereby release and discharge, and agree to indemnify and hold harmless, Brooks Rehabilitation and all affiliated or related entities, their respective officers, directors, trustees, employees, agents and representatives from any claims, liabilities and financial responsibility resulting from or arising out of any incident, injury or accident occurring while I am attending or participating in the observation activity or while the I am on facility property, excluding any claims or liabilities arising out of the gross negligence or willful misconduct of Facility, or its employees or agents.**

Click here to enter text.Click here to enter a date.

**Signature Date**

MANDATORY EDUCATION REVIEW

Please read the attached Mandatory Information in its entirety. Keep this packet as a reference while you are observing at Brooks Rehabilitation. By signing below, you are verifying that you have read this packet and understand its contents.

# Please read attached and sign below:

Click here to enter text. Click here to enter a date.

**Signature Date**

** Observation Program Guidelines**

 **Confidentiality & Security Agreement**

 **HIPAA**

**OBSERVATION PROGRAM GUIDELINES**

* **You are expected to look and behave in a professional manner at all times. Business Casual dress required.**
* **Do not use your cell phone for calls, texts, social media, or any other application while shadowing.**
* **If you no call/no show your confirmed observation, it will not be rescheduled.**
* **Must have reliable transportation.**
* **Do not come in to observe if you are ill or if you feel there is a possibility of infecting others.**
* **If you are unable to attend your scheduled hours, you must cancel your sign up no later than 48 hours before the scheduled observation (refer to the sign up confirmation email to access cancellation).**
* **Observation/Shadowing students are prohibited from any physical contact with any/all Brooks Rehabilitation patients.**
* **I UNDERSTAND I AM BEING GIVEN AN OPPORTUNITY TO OBTAIN AN OBSERVATION EXPERIENCE AT BROOKS REHABILITATION. IF I FAIL TO FOLLOW THESE GUIDELINES, IT WILL RESULT IN MY INABILTIY TO CONTINUE TO OBSERVE OR CONTINUE IN THE PROGRAM.**

**CONFIDENTIALITY AND SECURITY AGREEMENT**

I understand that the facility or business entity (the “Company”) in which or for whom I 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 patient identifiable health information, “Confidential Information”).

In the course of my assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will access and use this information only when it is necessary to perform my duties in accordance with the Company’s Privacy and Security Policies. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

* I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
* I will not in any way divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
* I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient’s name is not used.
* I will not make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information.
* I agree that my obligations under this Agreement will continue after termination of my relationship with the Company.
* 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.
* 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.
* 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.
* 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.

**HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT – HIPAA**

It is the obligation and policy of Brooks Rehabilitation to maintain the confidentiality of all patient information and to protect the patient’s right to privacy.

HIPAA requires that we protect our patients’ health information. Information accessed and shared is limited to “the minimum amount necessary” to perform your responsibilities. Always dispose of patient information in the secured locked bins located throughout the facility, keep confidential information out of public places, do not discuss patient information to anyone unless there is a “need to know”.

A HIPAA Privacy hotline has been established to investigate any concerns regarding privacy. The privacy hotline can be called using 1-866-TELL-BHS or 904-345-7676.

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

|  |  |
| --- | --- |
| **Student Signature:** Click here to sign. | **Facility Name Date****BROOKS REHABILITATION** Click here to enter a date. |



Brooks Rehabilitation - TB Screening Questionnaire for Non-Employees

PLEASE ANSWER ALL NO/YES QUESTIONS, SIGN & DATE

**Check all that Apply**

**Designation: Inpatient Hospital** [ ]  **Outpatient** [ ]  **SNU/F** [ ]  **Intern** [ ]  **Volunteer** [ ]  **Student** [ ]  **Contract** [ ]  **Clubhouse** [ ]  **Other** [ ]

**Name**: Click here to enter text. **Last 4** **SS #:** Click here to enter text.

**Home/Cell #:** Click here to enter text.

Dept Name: Brooks IHL Brooks Education Coordinator: Dale Muse, **345-7071**

##### **A. TB SYMPTOMS QUESTIONNAIRE (Contact EH if Yes)**

Persistent cough No [ ]  Yes [ ]  Weight loss w/o dieting No [ ]  Yes [ ]

Night sweat No [ ]  Yes [ ]  Loss of appetite No [ ]  Yes [ ]

Persistent fever No [ ]  Yes [ ]  Chest pain No [ ]  Yes [ ]

Chronic Fatigue No [ ]  Yes [ ]  Coughing up blood No [ ]  Yes [ ]

**I realize I must contact Employee Health (EH) if any of these symptoms are present.**

Comments: Click here to enter text. **Signature:** Click here to enter text.

##### **B. TB Screening History:**

Have you ever been screened for TB? No[ ]  Yes[ ]

*If yes, Please attach the most recent result.*

Have you ever had a **reaction (induration) to a TB skin test?**  No[ ]  Yes [ ]

Year:Click here to enter text.

Have you ever taken medications for TB (Isonaizid [INH])? No[ ]  Yes [ ]

Year:Click here to enter text.

Have you ever had a BCG vaccine/inoculation for TB? No[ ]  Yes [ ]

Year:Click here to enter text.

Have you ever been told your Chest X-Ray was abnormal? No[ ]  Yes [ ]  Year:Click here to enter text.

Are you pregnant or Breastfeeding? No[ ]  Yes [ ]

As far as you know, have you recently been exposed to TB? No[ ]  Yes [ ]
Are you immunocompromised? More susceptible to illness? No[ ]  Yes [ ]

**All F/u requirements mandated by the EH office will be at your own expense.**

**Signature:** Click here to enter text. **Date:** Click here to enter a date.

DO NOT WRITE BELOW THIS LINE

**This Section for EH Office Use only**

***\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\****

*TB Screening Completed: N \_\_\_\_\_\_Y\_\_\_\_\_\_ Date Completed \_\_\_\_\_\_\_\_\_\_\_* Referral Made? N\_\_\_\_\_ Y\_\_\_\_\_\_

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cleared For Duty? N \_\_\_\_\_ Y \_\_\_\_

Employee Health Staff: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

 rev 5/2013