Tomah Health
TOGETHER IN CARE

STUDENT INFORMATION

Full Name:	**Today's Date:**
Mailing Address:	**Daytime Phone:**
	Date of Birth:
Current School/College:	**Year in School:**
Rotation Dates:	**Department/Specialty:**
Do you have any major medical problems that we should know about? Yes ☐ NO ☐	
If yes, please explain:	

Emergency Contact

Name:	**Relationship:**
Address:	**Cell phone:** **Work phone:**
Notes:	

Signature of Student _____ **Date** _____

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NON-EMPLOYEE ORIENTATION ACKNOWLEDGMENT

By signing below, I acknowledge that I have reviewed the following orientation video:

- Non-Employee Orientation Video

These documents include but are not limited to the below topics:

- Employee Health/Infection Control
- Quality/Compliance/CMS Fraud, Waste & Abuse
- Fire and Safety
- Sexual Harassment
- Personal Appearance
- Security
- Emergency Alerts
- HIPAA

_____ _____
Name (*please print*) Department

_____
Name of School/Company/Contract

Dates in the facility from_____ to _____

_____ _____
Signature Date

Please forward to Professional Development when complete. 1/2024

TOMAH HEALTH
CONFIDENTIALITY AND SECURITY AGREEMENT

(for Non-Employee Persons participating in care reviews, debriefings)

I understand that the facility or business entity (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 patient identifiable 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 access and use this information only when it is necessary to perform my job related duties in accordance with the Company's Policies/Standards of Behavior available on HealthConnect (intranet), P&G Station and/or upon request. 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:

- access, disclose, or discuss any Confidential Information with others, including friends or family
- Divulge copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized
- Discuss Confidential Information where others can overhear the conversation
- Make any unauthorized transmissions, inquiries, modifications, or purging of Confidential Information
- Share/disclose user names, passwords, etc
- Use tools or techniques to break/exploit security measures
- Connect to unauthorized networks through the systems or devices

I AGREE:

- My obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company
- Upon termination, I will immediately return any documents, equipment, or media containing Confidential Information to the Company
- I have received training on how to protect health information/confidentiality as necessary and appropriate to perform my job responsibilities.
- I only receive confidential information on a need to know basis.

I UNDERSTAND:

- 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 Standards of Behavior at all times during my relationship with the Company
- That violation of this Agreement may result or law enforcement involvement based on circumstances and evaluation.
- I understand and agree that the computer login and/or electronic signature is equivalent to a legal signature.
- I understand and agree to use hospital issued equipment for business purposes and no expectation of privacy.

_____ _____

Signature Date

_____ _____

Printed Name Date

_____

Agency Represented

Return to Health Information Director

10/2022

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COVID-19 Student Attestation

By signing below, I attest that I will NOT come to clinical if I have a fever of (>100°F) or any of the following new unexplained symptoms: cough, shortness of breath, fatigue, muscle/body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting or diarrhea. If I develop any of the above signs or symptoms of COVID-19 or have had a known exposure to COVID-19, I will speak to my instructor prior to coming to clinical at Tomah Health.

Signature:_____

Date:_____

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Student Vaccine Attestation

By signing this document, I attest that I am up to date on the vaccines listed below. If requested by Tomah Health, my represented school would be able to provide documentation of the following:

- Hepatitis B x3 or immune titer
- Measles, Mumps, & Rubella (MMR) x2 or immune titer
- Tetanus, Diptheria, and Pertussis (Tdap)
- Negative Tuberculosis Skin Test(s) or Blood Draw (within the last 12 months)
- Varicella x2 or immune titer
- Influenza (October-April)
    - Must provide proof of this vaccine during these months. Please attach to this document.
    - If refusing the Influenza vaccine for a medical or religious reason, please request an exemption form.
        - For religious exemptions, please provide a brief explanation for the exemption.
        - For medical exemptions, please provide proof of allergy or a statement from your doctor.

Signature:_____

Date:_____