EDUCATION ONBOARDING PACKET

JOB SHADOWS AND OBSERVERS

We are so excited to have you onsite with us! To ensure that we are meeting our regulation standards, we will need some documentation from you for your upcoming job shadow.

DOCUMENTATION NEEDED:

In addition to the forms you will find in this packet, **we will need you to provide the following documentation**:

- Photo ID

FORMS TO COMPLETE:

- Education Application – Page 2
- Visitor Safety and HIPAA Acknowledgement – Page 3

In addition to the above forms, if you are shadowing at the SURGERY CENTER please complete the following:

- Surgery Center HIPAA Security and Confidentiality Agreement – Page 4
- Surgery Center Policies Acknowledgement – Page 5
    - Please sign this AFTER reviewing our policies and procedures. You can find the policies and procedures **HERE**.

Education Application – Job Shadow

PLEASE NOTE THAT EACH PERSON IS ALLOWED **ONE** SHADOW DAY IN CLINIC AND **ONE** SHADOW DAY IN THE OR.

Personal Information:

Full Name: _____ **Date of Birth:** _____

Phone: _____ **Email:** _____ **Last 4 of SSN:** _____

Institution/School You Attend: _____

Are you currently seeking a postsecondary degree?

- ☐ Yes (Specify Degree/Major: _____)
- ☐ No

Observation Information:

Please list the name of the OAM provider who has given you approval to shadow them.

_____

What dates and times, if any, do NOT work for you?

_____

_____

_____

Emergency Contact Information:

Name: _____

Phone Number: _____ **Relationship:** _____

- ☐ *I understand that should I need medical attention during or as a result of this clinical experience, I assume full responsibility for any treatments and associated medical costs deemed necessary. I release Orthopaedic Associates of Michigan from all liability.*
- ☐ *I understand that all healthcare information, patient care and records are a confidential matter. I agree that all information exchanged while I am observing will be held in strictest confidence.*

Signature: _____ **Date:** _____

Visitor Safety and HIPAA Acknowledgement

Visitor Safety Guidelines:
As part of our commitment to ensuring the safety and well-being of all patients, visitors, and staff, we ask that you adhere to the following safety protocols while in our facility:

1. **Personal Protective Equipment (PPE):** Please wear any PPE provided, including masks, gloves, and gowns, as required by the facility's policies.
2. **Health Guidelines:** Visitors experiencing any COVID-19, flu-like, or any other communicable disease symptoms should not be on-site and should reschedule. We kindly ask that you use hand sanitizers available throughout the facility and practice proper hygiene by washing your hands regularly.
3. **Restricted Areas:** Please follow any signage or instructions from staff regarding restricted or patient-sensitive areas within the facility.
4. **Emergency Protocols:** In case of an emergency, please follow the instructions from our staff promptly and calmly to ensure your safety and the safety of others.
5. **Identification:** If your school or organization provides you with ID, please wear this as a form of identification for the duration of your onsite visit with OAM.
6. **Equipment/Software:** Please do not use or operate any of the equipment, products, or computers unless otherwise instructed by your OAM preceptor.

HIPAA Acknowledgement:
In accordance with the Health Insurance Portability and Accountability Act (HIPAA), we are committed to protecting the privacy and confidentiality of our patients' health information. As a visitor to this healthcare facility, you are expected to adhere to the following guidelines:

1. **Confidentiality of Health Information:** Visitors are prohibited from discussing or sharing any patient health information, whether verbally, in writing, or in any form of communication. All patient health records and information are confidential and should be treated as such.
2. **Access to Patient Information:** Visitors will not be provided access to any patient medical records or personal health information, unless expressly authorized by the patient or a legal guardian.
3. **Photography/Recording:** Unauthorized photography, video recording, or audio recording of patients, staff, or any medical information is prohibited. This includes using mobile phones or cameras within patient areas. If any notes are taken, it must be de-identified and not include any personal data.
4. **Respectful Behavior:** We ask that you respect patient confidentiality and the privacy of all individuals in the facility, including both patients and staff.

By signing below, you acknowledge that you have read and understand the Visitor Safety Guidelines and the HIPAA Privacy Policies. You agree to follow all applicable protocols while visiting our office.

Visitor Name (Print): _____

Visitor Signature: _____ **Date:** _____

HIPAA

SECURITY AND CONFIDENTIALITY AGREEMENT
NON-EMPLOYEES

As an employee of a health-care staffing agency or a representative of a medical equipment/supply company, providing services to **OAM Surgery Center at MidTowne**, I agree to the following:

1. I understand that I am responsible for complying with the HIPAA privacy policies and procedures, which have been explained to me.
2. I will treat all information received in the course of my service with the **OAM surgery Center at MidTowne**, which relates to the patients of the health care facility, as confidential and privileged information.
3. I will not access patient information unless I have a need to know this information in order to perform my job and have been given express permission by a member of the health care facility's staff.
4. I will not disclose information regarding patients to any person or entity, other than as necessary to perform my job, and as permitted under the HIPAA Policies.
5. I will not log on to any of the **OAM Surgery Center at MidTowne's** computer systems that currently exist or may exist in the future.
6. I will not use e-mail to transmit patient information unless I am instructed to do so by the facility's Privacy Officer.
7. I will not take patient information from the premises in paper or electronic form without first receiving permission from the Privacy Officer.
8. Upon cessation of my temporary employment and/or service, I agree to continue to maintain the confidentiality of any information I learned while in service to the facility and agree to turn over any keys, access cards, or any other device that would provide access to the facility or its information.

I understand that violation of this agreement could result in a formal complaint to my employer and/or in my not being permitted to provide services to the facility in the future.

_____ _____
Name (print) Date

_____ _____
Name (signature) Witness

_____
Business/School

OAM SURGERY Center at MidTowne

Policies Acknowledgement – General Job Shadow

I have read the policies that were provided to me and agree to abide by them. I understand that if I am experiencing signs of infectious illness I am not to provide direct patient care. I understand that while working here I may be audited for quality purposes.

By signing my name below, I agree with the above statement.

Signature: _____ **Date:** _____

Full Name (Printed): _____