

Participant Name: _____

Emergency Contacts

In case of medical emergency, NC AHEC must be able to reach a relative or other emergency contact.

Primary Contact: Secondary Contact:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

Primary Phone: _____ Primary Phone: _____

Other Phone: _____ Other Phone: _____

Release of Liability

I hereby agree that while I am participating in any North Central MT AHEC educational experience, the NC AHEC, the Montana Hospital Association... An Association of Montana Health Care Providers, and the healthcare facility will not be held responsible for any injury or accident that might occur. Any medical expenses incurred as a result of such injury or accident will be my responsibility.

Participant Signature

Date

(Parent/Guardian Signature if participant is under age 18)

Medical Release

(For participants under age 18)

I understand that in case of a medical emergency, every attempt will be made to contact me before medical action is taken. However, this document is my consent as a parent or guardian of the participant for emergency treatment or procedure necessary by the professional staff of the closest hospital available.

Parent/Guardian Signature

Date

Participant Name: _____

HIPAA Training Test

1. You can tell other people you saw a patient at the hospital, as long as you don't look at their records.

- a. True
- b. False

2. Individuals can be held personally liable for privacy violations.

- a. True
- b. False

3. The privacy rule protects:

- a. Patient information transmitted electronically (faxes, e-mails, etc.).
- b. Patient information in paper form.
- c. Patient information communicated orally.
- d. All of the above.

4. It is acceptable to look at other patients' records even if it does not pertain to your job, as long as you do not pass this information along to anyone else.

- a. True
- b. False

5. In talking about patients, you should ask yourself:

- a. Is this confidential information?
- b. Is the person I am talking to part of the patient's healthcare team?
- c. Am I in a private place so others won't hear?
- d. Is sharing this information for the patient's benefit? Is it gossip?
- e. All of the above.

6. Betty's new patient, Mr. Jones, goes to Betty's church. Betty told her pastor that Mr. Jones was in the hospital and going to have surgery. This is okay because Mr. Jones would probably enjoy a visit from the church members.

- a. True
- b. False

7. You may look up patient information in the electronic health record for the following reason(s):

- a. If your co-worker needs information and doesn't have the appropriate access.
- b. To treat your patient.
- c. To access your minor child's record.
- d. To see who is in the Emergency Department.
- e. All of the above

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9. You should log out of the electronic health record:

- a. If you are going on a break or to lunch.
- b. If someone else wants to use the computer.
- c. If you are walking away from the computer for a few minutes.
- d. All of the above.

10. If people work in the same place you do, it's okay to discuss a patient with them.

- a. True
- b. False

HIPAA Privacy Attestation Form

The purpose of this agreement is to help you understand your obligations regarding confidential information that you may have access to. Confidential information includes information about specific patients you may see at the hospital, and/or their medical information.

Confidential information is protected by Federal and State laws, regulations, including HIPAA, and the Joint Commission on Accreditation of Healthcare Organizations standards.

As a visitor, you are required to conduct yourself in strict conformance with applicable laws, standards, and regulations.

In the event that you do have access to confidential information, you hereby agree:

- You will not in any way discuss, copy, release, sell, loan, review, alter or destroy any confidential information/data.
- You will not misuse confidential information/data or be careless with it.
- You understand that your obligations under this Agreement will continue after your visit to the healthcare facility ends.

Printed Name

Signature

Date

*Parent Signature required if participant is **under** age 18

Tuberculosis or PPD Skin Test

Consent for PPD Tuberculosis Skin Test

Participant Name: _____

I UNDERSTAND job-shadowing participants must receive a PPD skin test for Tuberculosis as part of pre-job shadowing requirements. I also UNDERSTAND IT IS MY RESPONSIBILITY to have the test read 48-72 hours after the test is given, by a validated TB test reader. This form **MUST** be returned to the NC AHEC office as part of the completed Job Shadowing packet.

My signature indicates my agreement to have the PPD test and follow up, and further indicates that I HAVE NEVER HAD A POSITIVE PPD TEST IN THE PAST.

Signature

This section to be completed by Health Care Provider

Date of Test

_____ 5 TU/0.1 ml _____

Pharmaceutical Company Lot #

Exp. Date Injection Site

Given by _____

Test results _____ Read by _____ Date _____

Neg Pos

If you have a current TB test on file you may submit a copy in lieu of completing this page.

Important Details

When you are in a shadowing experience, remember you are a representative of the facility, and there are expectations of professionalism. Arrive on time; dress and act professionally. Job shadowing is a privilege, not a right.

- DO NOT CANCEL your job shadowing experience. If you must, call the department contact to explain. RESCHEDULING IS NOT GUARANTEED.
- Wear clean, professional clothing: collared shirts, dress slacks (khakis are fine).
- Wear comfortable shoes, not high heels, not open-toed shoes/sandals.
- NO blue jeans, shorts, short skirts
- NO spaghetti straps or tank-tops
- NO visible body piercings, tattoos or jewelry
- Long hair must be pulled back
- Arrive ten minutes early, introduce yourself, and SMILE
- Use polite language and make eye contact
- Be respectful and engaged; show your interest
- Ask questions (when appropriate); you are here to explore the career
- Remember everything you see and hear is confidential. Keep information to yourself.
- NO smoking, tobacco chewing or gum chewing
- **Turn your cell phone OFF!**
- NO other electronic devices are allowed

I have read the statements above, and I understand that non-compliance with ANY of them can result in the immediate termination of the shadowing experience.

Participant Signature _____ Date _____

Please return your completed Job Shadowing Application to the following address:

North Central AHEC

P.O. Box 67

Fairfield, MT 59436

Questions? Please do not hesitate to contact the NC AHEC staff:

Director– Jody Haines 406-455-3315 or jody@mtha.org

Program Coordinator– Kailyn Dorhauer 406-994-7709 or kailyn.dorhauer@montana.edu