

Scotland Health Care System Non Employed Worker/Shadower N.E.W. Packet Answer Sheet

Name _____ Date _____

Department _____

Agency/School/Employer _____

Instructor _____ Expected Dates: _____

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Non-Employed Workers Orientation Roster

I have completed the orientation self-study and am responsible for the content.

Date _____ Signature _____

Department _____

Agency/School/Employer _____

PRINTED NAME _____

*The following documents need to be **submitted** and kept on file:

- **Orientation Roster**
- **Security and Confidentiality Agreement**

Group	Submit To:
Consultants, contract and agency personnel, students, intern groups	Scotland Health Care System Education Department: (choose one) <ul style="list-style-type: none"> ➤ interdepartmental envelope ➤ fax to 910-291-7948 ➤ mail to Education Department, Scotland Health Care System, 500 Lauchwood Drive, Laurinburg, NC 28352

Participant Evaluation Form

Title of Activity: Orientation Self-study for Non-Employed Workers	Date:				
We are interested in your evaluation of this program. Your feedback is extremely important in planning future educational offerings.					
	Strongly Agree	Agree	Disagree	Strongly Disagree	NA
I am satisfied with this educational activity.					
Educational activity objectives were met.					
I am leaving today with specific ideas I can apply to my work within Scotland facilities.					
This was an effective learning experience for me					
The information was given in a clear and concise way.					
For those items you marked "Agree", what would it take to move to "Strongly Agree"?					
What aspects of this learning experience were helpful?					
What did you learn that you plan to use in your work setting?					

Send this form to Scotland Health Care System Education Department.



Security and Confidentiality Agreement

As a non-employee of Scotland Health Care System and as a condition of my rotation and/or assignment, I agree to the following:

1. I understand that I am responsible for complying with the HIPAA policies, which were provided to me.
2. I will treat all information received in the course of my employment with Scotland Health Care
3. System, which relates to the patients of the health care system, as confidential and privileged information.
4. I will not access patient information unless I have a need to know this information for my assignment.
5. I will not disclose information regarding the health care system's patients to any person or entity, other than as necessary to perform my rotation and/or assignment, and as permitted under the HIPAA policies.
6. If applicable, I will not log on to any of the health care system's computer systems that currently exist or may exist in the future using a password other than my own.
7. If applicable, I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my ID badge.
8. If applicable, I will not allow anyone, including other associates, to use my password to log on to the computer.
9. If applicable, I will log off of the computer as soon as I have finished using it.
10. If applicable, I will not use e-mail to transmit patient information unless the appropriate security safeguards are in place and approved by my immediate supervisor.
11. I will not take patient information from the premises of the health care system in paper or electronic form without first receiving permission from the Privacy Officer.
12. Upon separation of my rotation/assignment with the health care system, I agree to continue to maintain the confidentiality of any information I learned while a non-employee and agree to turn over any keys, access cards/identification badge, or any other device that would provide access to the health care system or its information.

I understand that violation of this agreement could result in disciplinary action, including suspension of rotation/assignment.

Name (print & sign)

Date

Parent/Guardian

Date

CONSENT FOR MINOR TO PARTICIPATE IN SHADOW ACTIVITIES

This will authorize my/our child/ward _____, a minor to participate in such shadow activities at Scotland Health Care System, Laurinburg, NC, as from time to time may be prescribed by the System's Education Director or the designated representative. I (We) understand that my (our) child or ward services are donated to the hospital without contemplation of compensation or future employment.

I (We) release Scotland Health Care System and its employees from any claim of liability for any damages, injury or illness resulting to said minor, not occasioned by any fault or neglect on the part of the hospital, while participating in such shadow activities.

In the event said minor is in need of emergency medical treatment, I (we) authorize the Emergency Center physicians as my (our) agent to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of the hospital, whether such diagnosis or treatment is rendered at the office of said physicians or at said hospital. This authorization is given to provide in advance of any specific diagnosis, treatment, or hospital care being required, but is give to provide authority and power on the part of my (our) aforesaid agent(s) to give specific consent to any and all diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

Name (print & sign)

Date

Parent/Guardian Signature

Date

CONSENT FOR PARTICIPATION IN SHADOW ACTIVITIES

I release Scotland Health Care System and its employees from any claim of liability for any damages, injury or illness resulting to myself, not occasioned by any fault or neglect on the part of the hospital, while participating in such shadow activities.

I understand that my ward services are donated to the hospital without contemplation of compensation or future employment.

In the event I am in need of emergency medical treatment, I authorize the Emergency Department physicians as my agent to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of the hospital, whether such diagnosis or treatment is rendered at the office of said physicians or at said hospital. This authorization is given to provide in advance of any specific diagnosis, treatment, or hospital care being required, but is give to provide authority and power on the part of my (our) aforesaid agent(s) to give specific consent to any and all diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

Name (print & sign)

Date

Signature

Date