MEDICAL EDUCATION SERVICES

MEDICAL STUDENT CHECKLIST

STUDENT NAME: _____

SCHOOL: _____

SPONSOR: _____

ROTATION: _____DATES: _____

- ☐ Professional Headshot of student **(no selfies, please)**
- ☐ Contact Information (Email address, Cell phone number, etc.)
- ☐ Letter from school advising student in good standing
- ☐ Application completed **at least 30 days in advance from start date**
- ☐ Confidentiality statement completed
- ☐ PPD Status Reporting form completed
- ☐ Copy of PPD results and other immunizations (Flu, Covid, etc.)
- ☐ Verification of school's professional liability insurance coverage
- ☐ Information Systems Account Creation/Deletion form (only complete highlighted fields)

COMMENTS:

Please return application to the Medical Education Office at Archbold Memorial, 915 Gordon Avenue, Thomasville, GA, 31792

Ph- 229-228-2448 F- 229-584-7154

Student Supervised Educational Experience Application

Please complete **ALL** sections thoroughly and clearly.

Student Information

Today's Date:

Name:	DOB:
Mailing Address: (City, State, Zip)	
Email Address:	Phone Number:
Emergency Contact:	Phone Number:
Relationship:	

A letter from Medical School must be on file in the Medical Education Office prior to beginning your educational experience. The letter must include the following:

1. **Verify you are a student in good standing**
2. **Approval, naming this specific rotation**
3. **Specify exact dates of rotation**
4. **Verify your health status to perform duties requested**
5. **Professional Liability Coverage Carrier (attach a copy indicating policy number, amount of coverage and expiration date)**

Education Information

School:	Projected Graduation Date:
Program: ☐ MD/DO ☐ NP ☐ PA	School Contact:
☐ AA ☐ OTHER	Email:

Clinical Rotation(s) Needed

Specialty/ Sponsor	# of hours	Start Date: (Specific Date)	Rotation End Date: (Specific Date)

Check Appropriate Hospital: ☐ Archbold Memorial ☐ Archbold Brooks

☐ Archbold Grady ☐ Archbold Mitchell

Other Rotation details:

_____

_____

_____

_____

Check the correct answer; attach explanation for any *yes* answers.

☐ Yes ☐ No Have you ever voluntarily or involuntarily been suspended, restricted, or terminated from Any affiliation or relationship with any school or education facility?

☐ Yes ☐ No Have you ever received a formal reprimand or disciplinary action or been the subject of disciplinary proceedings or investigations at any school, hospital, or health care facility?

☐ Yes ☐ No Are any such proceedings in progress?

☐ Yes ☐ No Have you ever been charged with a crime other than a non-felony motor vehicle violation?

☐ Yes ☐ No Do you have or have you ever had a physical or mental condition (including drug or alcohol abuse) that could affect your ability to exercise the activities associated with this affiliation or would require accommodation in order for you to perform activities requested in a safe and competent manner?

☐ Yes ☐ No Do you currently suffer from any communicable disease that could be transmitted to patients or others?

I understand that in all contacts with patients, family, friends of patients, and staff of Archbold Medical Center (AMC) that I must wear a name badge and white coat identifying myself as a student. Additionally, I understand that I must verbally identify myself as a student and obtain oral permission to attend or be involved in the care of any patient with whom I may be assigned.

I understand that I must be supervised at all times by a physician who is a member in good standing of AMC.

I attest that all information furnished by me is true to the best of my knowledge and furnished in good faith, I understand that willful and significant omissions or misrepresentation may result in immediate termination of my affiliation.

I agree to report any changes in my school status or health status that would affect my ability to complete my affiliation as outlined by my sponsor.

PRINTED NAME _____

SIGNATURE _____ DATE _____

Archbold

CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT

WITH EMPLOYEES AND OTHER WORKFORCE MEMBERS OF ARCHBOLD*

As an employee, student, volunteer, or other member of Archbold's Workforce/Medical Staff, I acknowledge that I have completed Health Insurance Portability and Accountability Act ("HIPAA") training and:

1. I understand all patient and business information, in any format, is confidential, and I will access and use this information only when necessary to perform my job-related duties. I will keep such information confidential. This information includes but is not limited to clinical treatment, demographic, billing, financial, and identifiable information also known as Protected Health Information or "PHI."

2. I agree to respect and abide by all laws pertaining to the confidentiality of identifiable medical, personal, and financial information. I understand that I could be held civilly and criminally liable (through monetary fines and/or imprisonment) for improper use or disclosure of patient personal, financial, or medical information.

3. I agree to adhere to all Archbold policies and procedures related to HIPAA including the privacy, security, use/disclosure of protected health information and corresponding breach notification regulations.

4. I will secure my computer workstation at all times and practice good workstation security measures by logging out of applications and locking my workstation when my workstation is unattended. I understand if I use a workstation that is accessible to other users, I need to log out of any open applications before simply locking the workstation. I understand that, as a requestor of access or user of Archbold's computer system, my user login ID is the equivalent of my legal signature, and I will be accountable for all representations made at login and for all work done under my login ID.

5. I will safeguard my user login ID and password at all times. If I believe the security of my login ID and password has been compromised, I will immediately change it through the Archweb self- service portal or contact Information Services at 229-228-2959 to have my password changed. I understand that Archbold audits access and use of its computer systems.

6. I understand any security token/FOB used to remotely access Archbold's computer systems is to be used only by me. I am not to give this remote access token to any other individual.

7. I will not access patient information regarding myself, family members, or friends. I understand that I may access my information from Archbold patient portals or follow established Health Information Management Department procedures to obtain information from my medical record—just as any other patient does.

8. I understand that the misuse of my access to Archbold's computer systems (including accessing my own records, my family/friends' records or snooping), or of confidential information obtained, may subject me to disciplinary action up to and including termination of my access rights or my employment.

9. I understand I am only to discuss patient information with other workforce members who need to know that information to do their job. I understand I am not to discuss or disclose patient information outside the organization.

10. I understand specific administrative policies and procedures exist regarding the release of medical record information and release of patient condition information. Only designated individuals may disclose such information in accordance with specified procedures in Administrative Policies #105.06, "Release of Protected Health Information" and #101.02, "Release of Patient Condition Information."

11. I understand that my obligation to protect the confidentiality of patient and business information extends even after I terminate my employment or other relationship with Archbold.

12. I understand paper documents, CDs, and any documents containing PHI are to be placed in secure shred bins and are not to be discarded in regular trash.

13. I agree not to disclose patient information on any Internet-based websites or social media websites. I understand all patient information (even where the patient's name is not used) is confidential and is not to be disclosed in any manner to any outside party or to any workforce member unless that workforce member needs to know that information to do their job.

14. I understand I am to not capture any image or recording of a patient on my personal cell phone/device. Also, I am not to record by audio, video, camera or cell phone any interactions, meetings, or other interactions between employees, patients, family members, physicians, or guests without prior approval of Administration. If, in the course of my job responsibilities, my personal cellular device is authorized for use by Archbold for treatment, payment, or operational activities, I am only to use it for designated communication purposes with designated, secure communication applications for needed treatment, payment, or operational communications.

15. I agree not to send, forward, copy, print, download, remove, or inappropriately disclose PHI outside Archbold.

16. I agree to encrypt (use "Archsafe") all outgoing emails sent for treatment, payment or operational purposes that contain protected health information. I understand I am not to email PHI to private email addresses.

17. I agree I will not save PHI to unencrypted drives, laptops, CDs, phones, other portable devices, or online document storage applications including, but not limited to, DropBox, Google Drive, Amazon WorkDocs, etc. I understand I am to save business and patient information to secure network drives and not to my local workstation drive.

18. I will not alter, destroy, copy, or sell any PHI. I will only access and use PHI as properly authorized.

19. I understand if I have any questions or concerns about privacy and security of patient information and/or the proper use or disclosure of patient information, I am to discuss these with my Supervisor or Archbold's Privacy Officer at 229-228-2928.

20. I understand it is a condition of my job responsibility to immediately report any and all potential privacy or security incidents or breaches or any unauthorized/inappropriate access, use or disclosure of patient protected health information to Archbold's HIPAA Privacy Officer at 229-228-2928, or Information Services at 229-228-2959.

Signature: _____ Date: _____

Name:_____ Department: _____
(Print)

"Archbold" means (1) John D. Archbold Memorial Hospital, Inc., *which includes Archbold Memorial, Archbold Grady, Archbold Brooks, and Archbold Mitchell, and all of their on-campus and off-campus provider-based departments, facilities, rural health clinics, pharmacies, durable medical equipment provider, hospices; Archbold Northside, Archbold Living Thomasville, Archbold Living Camilla, Archbold Living Pelham, and Archbold Living Cairo; and* ***(2) Archbold Medical Group, Inc.****, which owns and operates multiple physician medical practices. Website www.archbold.org ("Locations" tab) explains more about Archbold locations.*

WELCOME TO ARCHBOLD!

MISSION

To Provide the citizens of South Georgia and
North Florida with high-quality, patient-focused healthcare in a cost effective-manner.

VISION

To be the Best Healthcare System in the region.

VALUES

Quality · Patient Experience · Financial Stewardship Community Benefit · Growth · Employee Satisfaction

CODE OF ETHICS

Our hospital's code of ethics directs that all patient care and business concerns are conducted in an ethical manner consistent with our mission, vision and values.

MAINTAINING PATIENT CONFIDENTIALITY

Archbold Medical Center is committed to the privacy of our patients and the security of their health and personal information at all times.

It is the policy of Archbold Medical Center to comply with the privacy and security requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As an individual taking part in an educational opportunity, you must adhere to these requirements. You should not access any information about a patient that is not required as part of your role. In the course of performing duties, you may come in contact with patient information and materials which are highly confidential. Information, records or materials concerning patient information may not be used, released, or discussed with anyone who is not involved in the care of the patient.

Patient's health information is the property of the Medical Center and must be carefully maintained to serve the patient, the healthcare providers and the Medical Center in accordance with legal, accrediting and regulatory agency requirements. All patient care information must be regarded as confidential and available only to authorized users.

All incoming calls and inquiries concerning a patient's condition must be referred to an employee authorized to handle such requests. Never discuss any information about a patient in elevators, corridors, the cafeteria, or at any other location where you may be overheard by others.

MEDIA
If you are approached by the media (a representative from a television or radio station, newspaper, etc.) you should refer them immediately to the Marketing and Public Relations Department at 584-5520. You should not answer any questions or make any comments to the media.

INFECTION CONTROL

Definitions

Infection: the entry and multiplication of a disease producing germ (an infections agent) in the tissues of a host (person).

Mode of transmission: the manner in which an infectious agent is transferred to the host. Commonly, on healthcare workers' hands or on contaminated equipment inadequately disinfected between patient contacts.

Prevention interventions: the measures used to control or eliminate the infectious agent and to interrupt its transmission to a new host.

Blood/body fluid exposure: any contaminated needle stick or sharps injury, splash or spray of blood/body fluids into eyes, nose, or mouth, or contamination of non- intact skin (scratch, dermatitis, laceration) with blood/body fluids.

Prevention Interventions

Standard Precautions: policy to prevent exposures to the blood and/or body fluids of ALL patients.

Hand washing: the single most important control measure for preventing the spread of infection. Use soap, paper towels and running water routinely.

Gloves: the use of gloves does NOT replace hand washing. Wear gloves whenever touching blood/body fluids, no-intact skin, mucous membranes, or contaminated items/surfaces. DISCARD AFTER USEAND WASH YOUR HANDS.

INFECTION CONTROL - CONTINUED

When to wash with soap and water:

- When hands look dirty
- When hands feel dirty
- After contamination - known/possible - by body secretions or excretions; especially after using the bathroom, coughing, sneezing or wiping the nose.
- Before eating or handling food
- When caring for or visiting sick people
- After handling money

When washing hands, please remember the following:

- Remove jewelry and push up sleeves
- Turn on water and adjust temperature
- Dispense soap
- Lather thoroughly and with vigor for 10-15 seconds
- Rinse well
- Dry hands with paper towel
- Now turn off water with towel
- Dispose of towel without touching waste container
- Use hand lotion to prevent chapping

When to use alcohol hand sanitizer

Anytime hands are not visibly soiled, but you know that you have touched something that is not clean.

INFECTION CONTROL - CONTINUED

Cough Etiquette

- Cover your cough or sneeze with a tissue. If one is not available, cough or sneeze into your elbow.
- Dispose of tissues properly
- Wash your hands after handling soiled tissues or coughing or sneezing into your hands.

Transmission-based isolation precautions:

DO NOT ENTER THE ROOMS OF PATIENTS ON ANY OF THE FOLLOWING:

- Airborne precautions - Blue Sign (e.g., chickenpox or tuberculosis)
- Droplet precautions - Green Sign
- Contact isolation - Yellow Sign (e.g., draining wounds or MRSA)
- Strict isolation - Tan Sign

SAFETY/EMERGENCY PREPAREDNESS

Safety and emergency preparedness is of utmost importance at the Medical Center. Listed below are the emergency codes used. Should you be here when a code is called, immediately find your supervisor/preceptor or a staff member and do as you are told.

Code Black Bomb Threat
If there is a true bomb emergency, the hospital operator will announce "Code Black" 3 times followed by instructions.

Code Blue
Code Blue Peds CPR
These codes are used when a cardiac or respiratory arrest occurs. Code Blue indicates adult and Code Blue Ped indicates pediatric. All of our staff have been trained in CPR and the proper response in the hospital setting. The hospital operator will announce "Code Blue and the location of the victim 3 times. (Code Blue room 101)" If you are in a patient's room or alone with a patient, and the patient has no pulse or respiration, notify someone in charge immediately to determine if the patient is a "No Code". If not, CPR should be initiated immediately and the code protocol activated. This is done by dialing 6 on the nearest telephone and advising the operator of the exact location of the incident. Each area has a "crash cart" specifically stocked for code situations. An ambu bag and code kit is located on the top of these carts. Please locate them and become familiar with them. The quicker the CPR is administered the better the outcome for the patient. Please remain in your designated
area during this event.

Code Decon Decontamination
Many materials found in the community and hospital can be health hazards if not managed properly. There are many governmental regulations that require safe handling, transportation, use and storage of these materials. The hospital has also taken action to reduce the threat of an internal hazardous materials exposure by limiting the amounts of chemicals stored at the facility and within the departments. In light of these regulations and safe practices, accidents will occur. The hospital trains staff members working with hazardous materials in proper utilization and handling, thus decreasing the likelihood of an incident within the hospital.

Code Green
Manpower Needed
The Code Green Emergency Call System is established to provide help to personnel for assisting with the care of patients and their families. Code Green is a twenty four (24) hour emergency code to be used only in the situation where by the hospital personnel in the immediate area needs assistance with a client such as lifting or moving a client, and in extreme cases the physical health of the person or others is in danger or where for some other impelling reason extra manpower is needed immediately. Mitigation for manpower assistance is difficult; however, the hospital has purchased equipment to assist staff in lifting patients.

A Code Green may be called after an unruly patient overwhelms security staff and additional assistance is needed. The hospital has a close relationship with local law enforcement to provide assistance as needed.

Code Grey Violent Event
Violence is random and unpredictable. This makes mitigation of these events difficult if not impossible. Through increased overall security, staff alertness and observations the risk can be lessened. Limited access doors are in areas of higher risk with general video monitoring of the facility. Additionally, we have a visible presence of security officers roving the facility and campus.

Code Lockdown Secure the Building
It is the policy of this facility to provide a safe environment for our patients and visitors. Code Lock-Down will be announced to alert hospital staff in the event the Hospital needs to be secured to prevent unauthorized entry or exit.

Code Orange Hazardous Materials
Many materials found in the community and hospital can be health hazards if not managed properly. There are many governmental regulations that require safe handling, transportation, use and storage of these materials. The hospital has also taken action to reduce the threat of an internal hazardous materials exposure by limiting the amounts of chemicals stored at the facility and within the departments. In light of these regulations and safe practices, accidents will occur. The hospital trains staff members working with hazardous materials in proper utilization and handling, thus decreasing the likelihood of an incident within the hospital.

Code Pink Infant Abduction
Used for a child up to the age of 12 years old is kidnapped. The operator will announce, "Code Pink: followed by the age and the sex of the child. (ex. Code Pink, zero, female) Upon activation of this code all hospital entrances and exits are closed and no one is allowed in or out of the building until "Code Pink all clear" has been announced 3 times by the operator. During this event, all staff members will be searching for a person with an infant or child fitting the description given of the victim. If the victim is an infant or small child, any and all items that are of sufficient size to conceal the child will also be searched. Please remain in your clinical area until the "Code
Pink all clear" has been announced.

Code Red Fire
This is the code for fire or smoke, one of the most life threatening situations that can occur in any health care facility. Every hospital employee receives fire safety education on an annual basis as well as frequently conducted drills. There is a good possibility that you will be here during a drill. The hospital operator will announce "Code Red" and the location 3 times. The staff will ask patients and visitors to remain in the patient's room with the door closed. If you are leaving any area of the hospital when the announcement is made DO NOT GET ON AN ELEVATOR and DO NOT WALK THROUGH CLOSED FIRE DOORS, remain where you are. Should you discover a fire, DO NOT SHOUT FIRE. Remove people from the room or immediate vicinity, close the door and pull the fire alarm. Once the fire has been contained and no danger exits, the hospital operator will announce "Code Red all clear" 3 times. Please look for the fire alarm boxes and fire extinguishers wherever you are in the hospital.

Code Triage Triage
This code is used in the event of a disaster. Our hospital has a disaster plan designed to provide care for a large number of people. Twice a year the hospital conducts a disaster drill. Each department and nursing unit is assigned certain duties, such as setting up a first aid station. The hospital operator will announce "Code Triage" 3 times followed by an explanation and instructions for visitors and hospital staff.

Code Weather Severe Weather
Thunderstorm warning, tornado watch, tornado warnings.

My signature below indicates that I have read and understand this orientation packet.

I have had the opportunity to ask questions and have had the questions answered to my satisfaction.

I understand that I am responsible for following the procedures outlined in this orientation packet.

SIGNATURE DATE

ARCHBOLD MEDICAL CENTER
P. O. Box 1018 • Thomasville GA 31799-1018
❑ AMH ❑ BCH ❑ GGH ❑ MCH

Name: _____ Employee #: _____Date: _____

TB RISK ASSESSMENT AND SYMPTOM EVALUATION

Please answer all of the following questions:

TB History

Have you had a positive TB test or PPD in the past?	**Yes ☐ No ☐**

TB Risk Assessment

Temporary or permanent residence for greater than one month in a country with a high TB rate? This includes any country other than the United States, Canada, Australia, New Zealand, and those in Northern or Western Europe?	**YES** ☐ **NO** ☐
Current or planned immunosuppression, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone > 15mg/day for > one month) or other immunosuppressive medication?	**YES** ☐ **NO** ☐
Close contact with someone who has had infectious TB disease since your last TB test?	**YES** ☐ **NO** ☐

TB Symptom Evaluation

Have you been experiencing any of the following symptoms?		
Unexplained fever	**YES** ☐	**NO** ☐
Coughing for longer than 3 weeks	**YES** ☐	**NO** ☐
Coughing up blood	**YES** ☐	**NO** ☐
Unexplained fatigue or tired feeling	**YES** ☐	**NO** ☐
Loss of appetite	**YES** ☐	**NO** ☐
Unexpected weight loss	**YES** ☐	**NO** ☐
Shortness of breath	**YES** ☐	**NO** ☐
Pains in chest	**YES** ☐	**NO** ☐

****For annual screening, an employee with a YES to "Coughing for longer than 3 weeks" and one other symptom should be referred to Corporate Care for evaluation and clearance.**

Employee Signature:_____ Date:_____

Form Reviewed By:_____ Date:_____

ARCHBOLD REGIONAL HEALTH SYSTEM

STUDENT – PPD/TST STATUS REPORTING

NAME: _____
(Print or Type)

TB Skin Test: _____
Results Date

My TB test converted to positive _____
Year

My last chest x-ray was _____ and the results were _____.
Date

My personal physician following this is _____.

1. Persons with a **positive TST** must submit a copy of a recent baseline chest radiograph within one (1) month to exclude diagnosis of TB.

2. Individuals who have had a **previous positive TST** MUST NOT be tested again. Please answer questions below.

TB Symptom Screen (Previous Positive TST)
Have you been having any of these symptoms? Please Circle

Unexplained fever	YES	NO
Coughing for longer than 3 weeks	YES	NO
Coughing up blood or excessive mucus	YES	NO
Unexplained fatigue or tired feeling	YES	NO
Loss of appetite	YES	NO
Unexpected weight loss	YES	NO
Shortness of breath	YES	NO
Pains in chest	YES	NO
Sweat excessively at night	YES	NO

_____ _____
Signature Date

History of a previous positive TST test or documentation of significant allergic response is the only contraindications for TST skin testing. Pregnancy is not a contraindication for administration of a TST skin test.

ARCHBOLD MEDICAL CENTER

P. O. Box 1018 • Thomasville, GA 31799-1018

STUDENT/INSTRUCTOR/NURSING RE-ENTRY CLINICAL CLEARANCE FORM

Route request to Departmental Clinical Contact
*******Please allow 2 WEEKS for account creation*******

Creation of user name only applies for one semester/quarter. A new request must be submitted each quarter/semester unless otherwise arranged.

Please check one of the following: ❑ New account (**If an Instructor provide DOB_____**)
❑ Returning Student/Instructor username**:** _____
❑ Correct Existing Account (please describe correction needed)
❑ Account Deletion/Inactivation (mid quarter/semester dismissal only)

Computer/System access requested: ❑ **NO access needed** ❑ **CERNER** ❑ **MAK (Med Admin)**
❑ Powerchart
❑ FirstNet
❑ PACS
❑ OmniceII
❑ Imprivata

Student Full Name: _____
(Please print) First Middle Last
Middle Initial and ID# MUST be included before a login can be issued

Student contact number: _____

Student ID:_____ **School:** _____

Hospital Orientation Date _____/_____/_____ **Computer Orientation Date:** _____/_____/_____

Instructor's Name, Phone #, & E-mail: _____

Rotation Dates - Start: _____/_____/_____ **End:** _____/_____/_____

Course of Study: (Please check one): ❑ **Clinical Rotation** ❑ **Preceptorship**, *if yes,*
Assigned Preceptor Name: _____ Unit: _____ Shift: _____
❑ RN ❑ LPN ❑ Respiratory ❑ Radiology ❑ Surgery ❑ Lab ❑ Business Office ❑ Cardio Tech
❑ Dietetics ❑ Pharmacy ❑ Medical Student ❑ Other: _____
❑ Therapy (select one): ❑ Physical ❑ Occupational ❑ Speech ❑ Recreational
❑ Nursing Re-Entry (NOTE: A copy of your nursing permit is required)

Facility/Site(s): _____ **Dept/ Unit(s):** _____

By signing this form, I, the instructor, certify the student is current with the following REQUIRED clinical clearance items through this semester/quarter, check all that apply (includes Archbold employees):

❑ BLS (American Heart) ❑ HIPAA Training ❑ Current Immunizations ❑ Flu Shot (during Flu Season)

❑ Student Liability Insurance current ❑ Student orientation completed/date to be completed: _____.

❑ Orientation packet completed & signed if unable to attend orientation

❑ PPD Date completed - _____/_____/_____. ❑ PPD neg. (❑ PPD pos. / ❑ Previous pos. / (follow-up required))

Within 2 yrs after school's admission date:
❑ **Drug screening** - (❑ Negative/❑ Positive/(results submitted to coordinator))

❑ **Background Check** completed by Pre-Check & submitted to Archbold's student coordinator for approval.
If Pre-Check was not used for the background check, a copy *MUST* accompany this form

Instructor's Signature **Date** **Student's Signature**

Special accommodations (e.g. Latex Free): _____

ARCHBOLD MEDICAL CENTER

P. O. Box 1018 • Thomasville, GA 31799-1018

STUDENT CONFIDENTIALITY AND NON-DISCLOSURE STATEMENT

All information pertaining to patient records, condition, personal details, and computer security is confidential. User names and passwords are not to be shared with anyone. Student is not to use his/her access to get information on patients or employees outside the student's direct care.

I, _____, a student/instructor in clinical rotation at Archbold Medical Center, acknowledge that I have reviewed and understand the policies set forth below. I have read, signed and agreed to abide by the Archbold Medical Center's Confidentiality Statement.

- I understand that all patient information in any format, including billing and financial data, is confidential.

- I agree to keep patient information confidential.

- I understand that my computer login ID is the equivalent of my legal signature, and I will be accountable for all representations made at login and for all work done under by login ID. I understand that data and information stored in the Medical Center's computer systems is confidential patient, financial, and organizational information, and I must treat it with the same care as data and information in paper records.

- I will safeguard my computer login ID and password at all times. If I believe the security of my login ID and password has been compromised, I will immediately contact my instructor.

- I agree to comply with all Health System Privacy Policies and Procedures including those implementing the HIPAA privacy rule. I understand specific policies and procedures exist regarding the release of medical record information and release of patient condition information. Such information is to be disclosed only by designated individuals and in accordance with specified procedures in Administrative Policies #105.06, "Release of Medical Record Information" and #101.02, "Release of Patient Condition Information."

- I understand that I will not access information regarding myself, family members, friends, patients, fellow students, employees, or members of the medical staff, unless it is relevant to the performance of my clinical rotation. I understand that I am to follow established Medical Record Department procedures to obtain clinical information from my individual medical record just as any other patient does.

- I understand if I have any question or concerns about the Privacy Rule and /or the proper use of the disclosure of patient information, I should ask my Instructor or clinical supervisor or the Medical Center's Privacy Officer/Compliance Officer.

- I understand and agree that the Health System Privacy Policies and Procedures will apply to any patient information I have access to at the Health System even after I complete my rotation or other relationship with Archbold Medical Center.

Student Signature: _____ **Date:** _____

(Please Print)
Name: _____ **School:** _____

ARCHBOLD MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

POLICY NUMBER: 101.02

EFFECTIVE: January 1992

SUBJECT: Release of Patient Condition Information

EXPIRES: When Superseded

APPROVED: _____
President

REVIEWED: January 2021

REVISED: January 2021

I. POLICY

It is the policy of Archbold Medical Center (AMC) to hold patient medical information in the strictest confidence, releasing only that information, within the law, which provides adequate representation of the patient's condition and only as a response to inquiries about the patient.

For the purpose of this policy, patients are divided into two categories - private patients and cases for public record.

II. PURPOSE

Patient condition information is considered part of the patient's medical record and may only be released in accordance with the law and proper authorization to protect the patient from unauthorized disclosure of patient medical information and the hospital from the implications of unauthorized disclosure of patient medical information.

III. SPECIAL INSTRUCTIONS

A. Private Patients

1. Private patients are identified as admissions (other than cases of public record: mental patients, drug or alcohol patients, assault victims and minors) in the Inpatient, Emergency Department and other outpatient departments.

    a. Under ordinary circumstances, acknowledgement of a patient's admission may be made without the patient's permission; and the general condition (not diagnosis) can be stated. However, the patient has the right to specifically request his/her admission not be reported to the news media or the inquiring public.

2. General Condition of the Patient

    a. If confined to very general terms, i.e., good, fair, serious, undetermined, this information may be released by the hospital. Any request for more specific information, if a worthy request, will be referred to the patient's family. Such information may be released by the hospital only if a

signed Authorization for Disclosure of Protected Health Information Form MR 107 has been given by the patient.

3. Guidelines for Determination of Patient Condition

a. Good - Vital signs are stable. Patient is conscious and comfortable.

b. Fair - Vital signs are stable. Patient is conscious. Patient is uncomfortable or may have minor complications.

c. Serious - Vital signs may be stable or not within normal limits. Patient is acutely ill; indications are questionable.

d. Undetermined - This is not a medical classification. It is to indicate the patient is in evaluation process to determine a more definite condition status.

4. Pictures

a. When newspapers, law enforcement officials or others request the privilege of photographing any patient in the hospital or on the hospital grounds, follow guidelines in Policy #101.57 Photography, Audio Recordings, or Video Recordings of Patient Data.

B. Cases of Public Record

1. Cases of public record are those involving the police, an accident, coroner's case, fire department, poisoning, etc., or any case which is reportable to a government unit.

2. Police and Accident Cases: The following items of public information may be given without the patient's consent: (a) name, (b) address, and (c) general condition (good, fair, serious, undetermined) as defined in paragraph III-A-3 above. However, no specific reference to type of injury, diagnoses, treatment, etc. is to be disclosed.

a. Nature of Accident. May not be stated. Refer to legal authorities.

b. Attending physician. May not be stated.

c. Condition of patient. The general condition (not diagnosis) may be stated if confined to the terms listed above. Requests for more than this routine information must be referred to the patient and/or his family or the proper legal authority.

d. Fractures. If there is a fracture it will not be described in any way.

e. Head injuries. There will be no mention of head injuries.

f. Internal injuries. There will be no reference to internal injuries.

g. Shooting or stabbing. No statement may be made.

h. Unconsciousness. No statement may be made.

i. Burns. No statement may be made.

3. Drug or Alcohol Intoxication. No information of any kind may be released.

4. Poisoning. No information of any kind may be released.

5. Sexual Assault. No information of any kind may be released.

6. Suicide or Attempted Suicide. No information of any kind may be released.

7. Death. Death of a patient is presumed to be a matter of public record and may be released by the hospital after the next of kin has been notified.

8. Mental Patients. No information of any kind may be released.

9. Child Abuse. No information of any kind may be released.

10. Minors. No information of any kind may be released. Minors are considered to be any patient age 17 and under.

C. Birth Announcements

Permission to announce the birth of a baby must be obtained in writing from the mother prior to the announcement being made to the news media.

D. Community Disasters

1. The hospital will make every effort to keep the news media informed.

2. Provision is made in the hospital disaster plan for a press information center supervised by Hospital Emergency Operations Plan for the Public Information Officer who serves as the point of contact to assist in tracking patients and providing information to families and for all community and media communications regarding event status and progress.

3. All information released will be in accordance with this policy herein stated.

E. News Gathering Equipment

Permission for utilization of news gathering equipment may only be authorized by the President or Assistant Vice President of Marketing. News gathering equipment will not be utilized when it will interfere with patient care or proper operation of the hospital.

Information regarding photographing patients is covered under III-A-4 of this policy.

F. Coroner's Case

No information may be released about coroner's cases. A coroner's case is indicated if any of the following questions could be answered "yes."

1. Was death due to suicide?

2. Was death due to suspected foul play or violence?

3. Was the victim a casualty of an accident such as an auto wreck, burns, fall, etc.?

4. Was the patient a prisoner when brought to the hospital?

5. Did the patient die within 24 hours of admission?

6. Did the patient die in any suspicious or unusual manner?

7. Was patient admitted due to a fractured hip or suffered a fractured hip during hospitalization?

8. Was the patient under seven (7) years of age (excluding newborns)?

G. Notable Persons

Notable persons are people whose presence in the hospital would be of considerable interest to the general public and news media. Such persons might include public officials, elected or appointed, and others prominent in the community. Information concerning notable persons will be released according to Section III-A, Private Patients.

IV. INSTRUCTIONS FOR HANDLING MEDIA INQUIRIES

Members of the media frequently inquire about the status of a patient, typically one requiring trauma care or relevant to some larger news story.

Any information to be released to the media regarding a patient's condition will be channeled through the Marketing Department. Any inquiries from the media received by other departments/areas are to be directed to Marketing.

In the absence of the Marketing Department staff, information for the news media should be provided, when possible, by the President, Senior Vice President, Vice President of Administrative Services, Vice President of Patient Care Services, Nursing Supervisor, Director of Emergency Department or Emergency Department charge nurse.

A. Procedures for handling media inquiries:

1. When a patient is brought to John D. Archbold Memorial Hospital (JDAMH) or

any system hospital, Marketing is to be called first. For JDAMH, Marketing will contact the Nursing Supervisor. For system hospitals, the Director of Nursing will be contacted. Marketing will identify his/her self and ask for the patient location and a one word condition (good, fair, serious, undetermined) report to release to the media. Use code word "101.02" to assure the nursing staff it is alright to release the condition. Marketing will relay only the one-word condition back to the media.

2. If the media tries to get more information or details, they are to be told that the hospital policy is to only release one of four conditions.

3. Refer back to AMC Policy 101.02 to determine how to convey the information you're about to release. DO NOT DEVIATE FROM THE SCRIPT.

V. JOHN D. ARCHBOLD MEMORIAL HOSPITAL, INC. (INCLUDING OPERATIONS D/B/A BROOKS COUNTY HOSPITAL, GRADY GENERAL HOSPITAL, MITCHELL COUNTY HOSPITAL, GLENNMOR NURSING HOME, MITCHELL CONVALESCENT CENTER, PELHAM PARKWAY NURSING HOME/ARCHBOLD FOUNDATION, INC./ARCHBOLD HEALTH SERVICES, INC./ARCHBOLD MEDICAL ENTERPRISES, INC./ARCHBOLD MEDICAL GROUP, INC.

A. As applicable.

ARCHBOLD MEDICAL CENTER
ADMINISTRATIVE POLICY MANUAL

POLICY NUMBER: 105.06

EFFECTIVE: September 1991

SUBJECT: Persons Authorized to Release Protected Health Information ("PHI")

EXPIRES: When Superseded

REVIEWED: October 2022

APPROVED: _____
President

REVISED: October 2022

I. POLICY

To provide a system for explaining who within the Medical Center may authorize the release of patient protected health information ("PHI") when requested and an appropriate authorization has been obtained.

See also Administrative Policy 105.44, Patient Right to Request Access to Protected Health Information, and Administrative Policy 105.31, Uses and Disclosure of Protected Health Information Requiring an Authorization.

II. PURPOSE

To protect the patient from unauthorized disclosure of PHI and the Medical Center from the legal implications of unauthorized disclosure of patient PHI.

III. INSTRUCTIONS REGARDING WHO WITHIN ARCHBOLD MAY RELEASE MEDICAL INFORMATION

General Rule: Patient's personal and health information should be kept confidential by all employees, students, Medical Staff members, volunteers, and all other workforce members who come in contact with the patient or patient's information, except as noted in this Policy, our HIPAA Policies and Procedures and our Notice of Privacy Practices. All other uses/disclosures of patient information require Authorization by the patient or patient's personal (legal) representative.

A. **Use and Disclosure for Treatment.** Patient information may be used and disclosed as needed to treat the patient by clinical personnel directly involved in patient's care.

B. **Release of Patient Information for Billing.** Clinical and Financial departments/areas within the Medical Center may release patient information periodically for patient care or payment purposes. The applicable Department Head or designee will be responsible to determine the purpose of the release, obtain appropriate authorization if needed, and release the appropriate amount of information.

C. **Release of Records for Third Party Billing.** Health Information Management or Patient Financial Services may release PHI for billing. Authorization for release of PHI solely for the purpose of filing a claim to a third-party payment source on behalf of a patient should ideally be obtained prior to treatment, typically during registration process.

However, in emergency situations where patient is not able to sign an Authorization Form, then PHI may be released as applicable for payment purposes.

D. **Release of Medical Records.** All requests for copies of patient records should be referred to Health Information Management Department or its designee. Health Information Management Department personnel may release or authorize the release of patient records from the Medical Center.

The original patient record will never be released, only a copy of requested records will be provided. Review of the record may be allowed with the approval of the Director of Health Information Management.

Except for patient-initiated requests, third party requests for records may be charged Georgia law per page rates. See also Administrative Policy 105.44, Patient Right to Request Access to PHI, for procedures related to patient right of access to medical records and fees that can be directly charged to patients.

Regarding legal requests in which it appears the patient may be seeking a claim against a physician who is a Member of the Medical Staff, the physician may be given a courtesy notification before releasing the information. Releases will be approved by Risk Management prior to such release.

E. **Third Party Financial Auditor Requests.** All requests by third party financial auditors to review records will be referred to the Health Information Management or Revenue Integrity Department (as applicable). Upon presentation of appropriate identification and after ensuring that the proper authorizations have been obtained, a review of the health information may be permitted.

F. **Medical Staff Access to Patient Information.** Members of the Medical Staff may request that a patient or treating provider be provided a copy of the patient's record (for continuity of care purposes), or may request a copy or have the privilege to review a patient's health information without written Authorization from the patient under any of the following conditions:

1. The physician is directly involved with the treatment of the patient;

2. The physician is conducting bona fide research related to some aspect of the patient's care, or;

3. The physician is acting in an official capacity (e.g. peer review, quality committee, Medical Director, Chief of Staff/department, administrator, etc.) as a representative of the Medical Staff / Medical Center and is in need of the information to fulfill a job responsibility.

G. **Release of Sensitive Information.** The Medical Center and any department releasing sensitive protected health information (such as mental health information, AIDs/HIV or other communicable disease information, alcohol and drug information, etc.) should ensure appropriate consent/Authorization is obtained prior to disclosure if needed. See

Administrative Policy 105.31, Uses and Disclosures of PHI Requiring Authorization, Form MR 107, Authorization for Use and Disclosure of Protected Health Information, and Form ADMT 126, Consent for Common Treatments/Procedures and Use and Disclosure of Medical Information.

H. **Release of Information Related to Job Duty**. In the course of performing their duties, Medical Center employees / workforce members may review a patient's protected health information without prior written authorization from the patient if the reason is work related.

I. **Release of Patient Information to Students.** Students enrolled in courses of study that requires clinical rotation in the Medical Center may have a need to access/review patient information to complete an assignment. Health Information Management Department may allow release of patient information upon written request from the appropriate Department Head or instructor, specifying the type of patient who is the subject of the assignment.

J. **Release of Information Law Enforcement.** Requests from law enforcement officials for copies of health information may only be honored by the Health Information Management Department. Requests may be granted only if the following conditions exist:

1. Authorization in writing is received from patient;

2. A court order requirement; or

3. Request meets a HIPAA Law Enforcement Exception.

See Administrative Policy 105.58, Reporting of PHI for Law Enforcement Purposes and Disclosing PHI in Response to Law Enforcement Requests.

K. **Court Orders.** All releases of information to courts and attorneys will be approved by Risk Management. Disability claims, automobile accidents, and worker's compensation insurance claims involving attorneys will be excluded from review by Risk Management.

L. **State, Federal, and Accreditation Agencies.** Certain other state and private agencies requesting protected health information will be handled in accordance with existing laws and current Health Information Management Department policy.

M. **Continuity of Care**. Health Information Management Department may release information without patient authorization to facilities or health service providers if it is deemed by the treating physician that the immediate release of certain protected health information is necessary to assure continuity of care.

N. **Referring Provider.** Appropriate clinical information concerning patients referred by other health service providers to the Medical Center for evaluation and/or treatment for which Medical Center personnel are responsible may be submitted back to the referring health service provider as a matter of courtesy (e.g., reports of results from labs, physical

therapists, respiratory therapists, certified nurse midwives, etc.) for continuity of care.

O. **Patient Condition.** Patient condition information will be released in accordance with Administrative Policy 101.02, Release of Patient Condition Information.

IV. JOHN D. ARCHBOLD MEMORIAL HOSPITAL, INC. (INCLUDING OPERATIONS D/B/A BROOKS COUNTY HOSPITAL, GRADY GENERAL HOSPITAL, MITCHELL COUNTY HOSPITAL, GLENN-MOR NURSING HOME, MITCHELL CONVALESCENT CENTER, PELHAM PARKWAY NURSING HOME)/ARCHBOLD FOUNDATION, INC./ARCHBOLD HEALTH SERVICES, INC./ARCHBOLD MEDICAL ENTERPRISES, INC./ARCHBOLD MEDICAL GROUP, INC.

A. As applicable

ARCHBOLD MEDICAL CENTER

POLICY NUMBER: 800.07

EFFECTIVE: 11/15/2021

SUBJECT: COVID-19 Vaccination Policy

EXPIRES: When Superseded

APPROVED: _____
Vice President of Human Resources

REVIEWED: Annually

REVISED: 6/1/2022

I. POLICY

Archbold Medical Center will comply with the Centers for Medicare and Medicaid (CMS) Omnibus COVID-19 Health Care Staff Vaccination Interim Final Rule requiring hospitals and other healthcare facilities to vaccinate all staff and applicable individuals with an approved COVID-19 vaccine by the dates specified in the final rule.

This policy is subject to change at any time as dictated by immediate circumstances or changes in governmental regulations.

II. PURPOSE

To maintain a safe facility for our patients, employees, medical staff, volunteers, and visitors as well as to comply with Federal regulations.

III. REGULATORY CITATION

42 CFR 418.60 (Hospice); 482.42 (Hospitals); 483.80 (Long Term Care Facilities); 484.70 (Home Health Agencies); 485.640 (Critical Access Hospitals); 491.8 (Rural Health Clinics)

[CMS-3415-IFC]

IV. PROCEDURES

A. The following individuals (regardless of clinical responsibility) are covered by this mandate:
   1. Clinical and non-clinical employees
   2. Physicians and other licensed practitioners who admit or treat patients in our facilities
   3. Students, trainees, and volunteers
   4. Individuals who provide care, treatment, or other non-clinical services at our facilities or for our patients under contract or other arrangements.

B. Individuals not covered by the mandate:
   1. Staff who exclusively provide telehealth or telemedicine services outside of Archbold and who do not have any direct contact with patients or other staff members
   2. Staff who provide support services for Archbold who perform exclusively outside our facilities and who do not have direct contact with patients or other staff.

C. Exemptions. Archbold will engage in an interactive process to determine if a reasonable accommodation can be provided. Individuals requesting an exemption must use the forms included in this policy. All questions must be answered, and no other forms will be accepted.

1. Medical

a. Staff members requesting an exemption due to medical contraindications must provide proof of medical complication via a written letter from a physician or other qualified healthcare provider that has current details of the medical contraindication. This letter needs to specify the allergy testing that was completed, if any; documentation of anaphylaxis post vaccination in the emergency room; documentation of Guillain-Barre syndrome if for the COVID-19 vaccine, or other contraindications that are recognized by the Centers for Disease Control and Prevention. Requests should be submitted to the Human Resources Department by the deadline set by Archbold Medical Center consistent with the recommendations of the Centers for Disease Control and Prevention. This deadline may vary from year to year. Individuals who have been extended an offer of employment must seek an exemption prior to beginning employment if their employment start date is after the deadline established by Archbold Medical Center. Staff may request an exemption at any time before the deadline.

b. Only evidence-based medical contraindications against vaccination confirmed by healthcare providers will be accepted as an exception to the mandatory vaccination requirement.

c. If exemption is granted for a temporary health condition, a new request for exemption must be made each year to which the condition applies. If exemption is granted for a permanent condition, the exemption does not need to be requested each year unless vaccine technology would change or eliminate issues regarding allergies.

d. Must complete and submit HR Form 250 - Request for Medical Exemption from COVID-19 Vaccination and have your medical provider complete HR Form 249 then submit both forms to the Human Resources Department.. Provider based forms may suffice and will be reviewed on a case by case basis.

2. Religious

a. Religious exemption requests will be considered for required COVID-19 vaccinations, and such exemption requests will be managed by Human Resources. Exemption to a required vaccination may be granted based on an individual's religious beliefs. For purposes of this policy, "religious

beliefs" include those that are theistic, as well as non-theistic moral or ethical beliefs as to what is right and wrong which are sincerely held with the strength of traditional religious views. Personal preferences do not constitute religious beliefs.

Staff requesting an exemption due to religious beliefs must complete the Request for Religious Exemption form by the deadline. Individuals who have been extended an offer of employment or other staff assignment must seek an exemption prior to beginning service if their start date is after the deadline. Staff may request an exemption at any time before the deadline. Staff will have to provide valid documentation of their religious faith outlining the specific faith-based concerns against vaccination.

Requests for exemption due to religious beliefs will be evaluated by Human Resources applying standards established in Title VII of the Civil Rights Act of 1964 and/or applicable state and local laws relating to religious accommodations in the workplace. Responses to timely requests for religious exemption should be provided, via email, within five business days of the date they are presented to Human Resources. Additional information may be requested if necessary to adequately evaluate a request for religious exemption. In such cases, responses should be provided, in writing, within 5 business days or prior to the deadline.

b. The staff member will be notified via email regarding the status of her or his religious exemption request.

c. Must complete and submit HR Form 248 - Request for Religious Exemption from COVID-19 Vaccination – to the Human Resources Department.

3. Accommodations
Individuals who receive an exemption may be required to comply with one or more of the following:
    a. Additional PPE requirements
    b. Temporary reassignment
    c. Employees may be placed on a leave of absence with or without the use of PTO
    d. If no accommodation is available then employees may have to be terminated from employment
    e. Weekly COVID-19 testing.

D. Tracking and Monitoring

1. Archbold will track the vaccine status of all employees and applicable individuals through the Disease Management Department.

2. Employees and applicants will submit their vaccination cards or exemption request to Human Resources. Cards will be sent to Disease Management to be checked against applicable database and entered into our employee health system.

3. Employees and applicable individuals who receive the vaccine from a provider other than Archbold are to provide that documentation promptly.

4. Contract staff exemptions are the responsibility of the contract company. They must provide a list showing both fully vaccinated and exempt staff when requested. Contractors abide by our policy on vaccine status.

E. Required Compliance Date

1. All individuals covered by this mandate must provide proof of vaccination with their first shot of any of the approved vaccines (Moderna, Pfizer, or Johnson and Johnson) or have an approved exemption by February 14, 2022.

2. All individuals covered by this mandate must be fully vaccinated or have an approved exemption by March 15, 2022.

3. Staff who are currently on a leave of absence beyond the dates above must submit proof of vaccination before returning to work.

4. No one will be able to start or continue to work until fully vaccinated or approved for an exemption. This would include new hires. Current employees would be placed on suspension until fully vaccinated.

V. JOHN D. ARCHBOLD MEMORIAL HOSPITAL, INC. (INCLUDING OPERATIONS D/B/A BROOKS COUNTY HOSPITAL, GRADY GENERAL HOSPITAL, MITCHELL COUNTY HOSPITAL, GLENN-MOR NURSING HOME, MITCHELL CONVALESCENT CENTER, PELHAM PARKWAY NURSING HOME)/ARCHBOLD FOUNDATION, INC./ARCHBOLD HEALTH SERVICES, INC./ARCHBOLD MEDICAL ENTERPRISES, INC./ARCHBOLD MEDICAL GROUP, INC.

A. No changes.

ARCHBOLD MEDICAL CENTER
P. O. Box 1018 • Thomasville, GA 31799-1018

❑ AMG ❑ AMH ❑ BCH ❑ GGH ❑ GMNH ❑ MCC ❑ MCH ❑ PPNH ❑ VNA

Request for Religious Exemption from COVID-19 Vaccination

Name:_____
Employee Number:_____
Department:_____
Job Title:_____
Date of Employment:_____

Explain in your own words why you are requesting this exemption.

Describe the moral, ethical or religious principles that guide your objection to immunization.

Are you opposed to all immunizations? If not, please describe the moral, ethical or religious basis that prohibits particular immunizations.

Have you received any vaccinations in the last five years?

If yes, when?

If yes, what vaccines?

I hereby affirm the truthfulness of this statement.

Signature: _____ Date: _____

ARCHBOLD MEDICAL CENTER
P. O. Box 1018 • Thomasville, GA 31799-1018

❑ AMG ❑ AMH ❑ BCH ❑ GGH ❑ GMNH ❑ MCC ❑ MCH ❑ PPNH ❑ VNA

Request for Medical Exemption from COVID-19 Vaccination

Name:_____

Employee Number:_____

Department:_____

Job Title:_____

Date of Employment:_____

Explain in your own words why you are requesting this exemption.

Provide the attached correspondence to your medical provider and return with your exemption request.

I hereby affirm the truthfulness of this statement.

Signature: _____ Date: _____

ARCHBOLD MEDICAL CENTER
P.O.Box 1018 * Thomasville, GA 31799-1018

Dear Medical Provider,

Archbold Medical Center requires vaccination against COVID-19 as a condition of employment and as required by federal regulation. The individual named above is seeking an exemption to this policy due to medical contraindications. Medical contraindications and precautions for immunization should be based on the most recent recommendations of the Advisory Committee on Immunization Practices/CDC.

Please complete this form to assist Archbold Medical Center in the reasonable accommodation process.

It is my medical opinion that the person named above should not receive any of the following *COVID-19 vaccinations, Pfizer, Moderna, or Johnson and Johnson* due to:

___ Severe allergic reaction (e.g. anaphylaxis) after a previous dose or close to a vaccine component. Please provide the dates of allergy testing and the results of such testing:

___ Other (explain, attach additional sheets as necessary):

This exemption should be:

- ☐ Temporary, expiring on: __/__/____, or when _____
- ☐ Permanent

I certify the above information to be true and accurate, and request exemption from the COVID-19 vaccination for the above-named individual.

Medical Provider Name (print):	
Medical Provider Signature:	Date:
Practice Name & Address:	Provider Phone:

EXEMPTION REVIEW PROCESS

1. Exemption forms will be submitted to HR for review
2. If forms meet basic exemption criteria then HR will notify the staff member
3. If there is a question about the form it will be reviewed by Senior Management to determine next steps*
4. If Senior Management approves then HR will notify the staff member
5. If Senior Management does not approve then form(s) will be returned to staff member for clarification
6. If staff member resubmits their form it will be reviewed again and either approved or denied

*Senior Management may reach out to the Medical Staff Office for assistance in reviewing medical exemption

STUDENT PRECEPTORS – HIPAA CHECKLIST FOR STUDENT ORIENTATION

- Make sure all student clearance paperwork (IS-112) is complete, signed, and on file within the department.

- Forward requests for student user access to Information Services (ISAccessRequest@archbold.org) so that each student receives their own user ID and password for each rotation.

    - No one is to share their user ID/login information with anyone.
    - All computer access is to be under the student's login ID at all times.

- During the initial orientation with the student, ask the student to confirm they actually read and understand each bulleted item on the Student Confidentiality and Non-Disclosure Statement. (Page two of Form IS-112.)

- Confirm that the student has received HIPAA education. If not, the student must receive it. The Healthstream HIPAA Privacy and Security course assigned to all employees is a resource. They can also contact Archbold's Privacy Officer at 228-2928 or jjones@archbold.org.

- Even if the student verbalizes they are familiar with HIPAA, emphasize the importance of:

    - protecting patient privacy;
    - realizing the student's obligation to protect patient privacy and the information they access during their rotation lasts forever—even after their student rotation ends;
    - avoiding any situations through social media, group messages, snap-chat, friends, fellow students, coworkers, etc. where the student may inadvertently disclose patient information;
    - not taking pictures, video, or any recordings of patients on their cell phone/mobile device;
    - not texting any patient information;
    - not copying or removing any patient medical records from the facility; and
    - remembering they can be individually liable for HIPAA violations—which can result in civil and criminal penalties. (Civil means money; criminal means jail.)

- If the student will have any case studies or class assignments, the instructor is to assign the type of patient scenario, diagnoses, treatment, etc. The student is to provide that assignment criteria to the Director of Health Information Management who will select an applicable patient encounter for the assignment. The student may not make the selection themselves from family, friends, etc., they know personally who may meet the assignment criteria.

COLQUITT REGIONAL MEDICAL CENTER

IS Confidentiality Agreement for Computer Use

Applicant's Name _____ Emp. ID: _____
(Please print. First, Middle Initial, Last)

Vendor / Dept. _____ Date of Birth: _____
[mm/dd/yyyy]

I agree to keep patient information confidential by observing the following:

1. I will protect my password from use or theft by others.
2. I will sign off/log off the system when I leave the workstation and not allow others to use my access.
3. I will only look up information on patients for whom I have direct responsibility. I will not look up my own medical information on the computer.
4. I will share patient information only with people who have a right to access the information in order to perform their job function.
5. When sharing information with people who have a right to access the information in order to perform their job function, I will ensure that I am in a private setting where others cannot hear or see the confidential information.
6. I will follow all Hospital and department rules of conduct whenever I use e-mail.
7. I will password protect any mobile device that contains patient (or confidential) information.
8. I will not disseminate confidential patient information from non-Hospital supported computer/device without appropriate authorization for release of information.
9. I will dispose of confidential information properly in accordance with all applicable policies.
10. I understand that audits will be performed on computer usage to ensure compliance with all computer related policies and this confidential agreement.
11. I will follow other specific confidentiality rules for special situations. When departments have standards more stringent than this statement, I will abide by their standards.
12. I will comply with the enterprise electronic signature policies and protect my electronic signature when issued to me from use or theft by others.
13. I understand that my employer has the right to take disciplinary action up to and including termination of my employment for breaches of confidentiality. I acknowledge that I have read and agree that violation of policies and procedures may lead up to disciplinary action, including termination.

_____ _____
Signature Date

This form is kept on file with Colquitt Regional Medical Center Information System Security.