CONFIDENTIALITY ACKNOWLEDGEMENT FORM FOR SHADOWING/OBSERVATIONAL EXPERIENCES

When you participate in a shadowing or observational experience at Bellin Health, you are involved in a unique experience. You will be shadowing a health care professional for a specified period in a health care facility. During this time you will or may be seeing patients with a variety of medical issues and/or you may see and hear confidential information relating to these patients.

It is against the law to disclose: Individually identifiable patient information that is transmitted electronically, maintained in any electronic medium, or transmitted or maintained in any other form or medium (including written or oral communication). This relates to information about past, present and future:

- Physical and mental health;
- Provision of health care to the patient; and
- Payment for the patient's health care.

As a condition of participating in this shadowing/observational experience, I understand and agree:

1. That everything about a patient's health care is confidential.
2. To not discuss this confidential patient information with anyone except the health care professional that I am shadowing. I am welcome to ask the health care professional questions during this program, but I may not disclose this information to anyone else.
3. To not access protected or confidential information.
4. To abide by the dress code as directed by the department contact person.
5. To use proper language and a respectful manner at all times.
6. To seek out and follow the directions of the supervising person/person in charge, especially in any code situations and in the case of other safety or procedural questions.

_____
Print or Type Name

Date_____ Signature_____

First Name: _____ Last Name: _____

Street Address:_____

City, State, Zip: _____

Phone Number(s): Home = _____ Cell = _____

Emergency Contact: _____

Relationship: _____ Phone Number: _____

To be completed by Bellin Staff:
Clinical Area/Department of Shadow/Observation: _____

Date(s)/Time(s) of Shadow/Observation (must be completed or form will be returned):

_____

Bellin Clinician Supervising Student On-site (First and Last Name):_____

Immunization/Vaccination History Requirement Verification (Observer must submit official documentation)**:**
MMR vaccine/titer date: _____ Flu Vaccine date: _____
*Flu vaccination required for ALL students observing during flu season (generally November 1 – March 31, but subject to change on a yearly basis dependent upon influenza activity in the region). NO EXCEPTIONS.

FOLLOWING SHADOW/OBSERVATION, RETURN COMPLETED FORM(S) VIA **INTEROFFICE MAIL TO:**
Professional Development Coordinator, Nursing Administration