(Baptist Health Hardin)

Statement of Understanding and Confidentiality Agreement

I, ______________________________________, by signing this Statement of Understanding and Confidentiality Agreement, do hereby represent that I have read and understand the following:

1. A shadowing or clinical learning experience has been arranged for me at Baptist Healthcare System, Inc. d/b/a Baptist Health Hardin ("Hospital") as part of an agreement with my school.
2. I understand that this experience does not entitle me to any wages, workers' compensation, other benefits or guaranteed employment with Hospital.
3. While shadowing a Hospital employee performing duties or participating in a clinical experience at Hospital, I will conduct myself in accordance with Hospital policies and standards of conduct.
4. I understand that Hospital is not responsible for injuries that I incur solely as a result of my own negligence. I acknowledge that I will be responsible for paying for any medical treatment I receive as a result of injuries incurred during the course of my experience and that I am encouraged to maintain personal health insurance.
5. I understand that I may be required to have current TB tests and immunizations and that Hospital is not responsible for my exposure to any communicable diseases during this experience.
6. I understand that information regarding patients or former patients is confidential. I agree to permanently maintain the confidentiality, privacy and security of all patient information obtained during my experience. I further understand that an inability to maintain patient confidentiality during this experience may result in immediate dismissal and/or additional legal ramifications.
7. I understand that any action on my part that is not fully consistent with the above statements may warrant termination of this experience.
8. I understand that I may be required to undergo a criminal background check, Medicare/Medicaid exclusion check, and/or drug screening.
9. I understand that Hospital may terminate my experience at any time, with or without cause.

I have read and understand the above statements and accept them as conditions of my experience at Hospital.

Signature: _____________________________ Date: _________________

Printed Name: ____________________ Email Address: ______________________________

Witness Signature: _________________________ Phone Number: ____________________________

If Minor,
Parent/Guardian Authorization

I have read and understand the above statements and give authorization for ____________________________ to participate in the shadowing experience pursuant to such conditions. I further authorize any and all healthcare providers to render emergency medical assistance and/or treatment that may become necessary as a result of any injury sustained during the course of the shadowing experience. I understand I will be financially responsible for any medical care rendered.

Parent Signature _____________________________________

Print Parent Name ___________________________________

Relationship to Student _______________________________