

4. Confidentiality. Clinical Observer will have access to patient information and Jefferson Health - New Jersey information of a confidential and/or proprietary nature, including, but not limited to, patient medical information, patient demographic information, and information regarding Jefferson Health - New Jersey's provision of healthcare and practices ("Confidential Information"). Clinical Observer will (a) secure and protect the Confidential Information consistent with standards and laws applying to the security and protection of patient information, including, but not limited to, any such regulations under the Health Insurance Portability and Accountability Act of 1996, and any applicable state privacy and security legislation or regulations, (b) will not use the Confidential Information except to achieve the Purpose under these Terms and Conditions, and (c) will not disclose the Confidential Information except to those individuals providing medical care to the patient. This restriction will not apply to Confidential Information the Clinical Observer is required by law, regulation, rule, or court order of any governmental authority to disclose if Clinical Observer first notifies Jefferson Health - New Jersey as soon as possible, but in no event less than fifteen (15) days, prior to disclosure, and cooperates with Jefferson Health - New Jersey in any response to such required disclosure. In addition, Clinical Observer will immediately inform Jefferson Health - New Jersey of any disclosure of Confidential Information to anyone, whether or not permitted by this agreement or any other agreement between Clinical Observer and Jefferson Health - New Jersey. If Clinical Observer receives any Confidential Information, he or she will return it to Jefferson Health - New Jersey or destroy it the sooner of the end of the procedure or upon Jefferson Health - New Jersey's request.

5. Representations and Warranties

- a.** Clinical Observer represents and warrants that he/she is aware of Jefferson Health - New Jersey's safeguards against the introduction of infection and that he/she is not aware that he/she has any infectious disease. Clinical Observer represents and warrants that he/she will comply with all safeguards against infection and other hazards.
- b.** Clinical Observer represents and warrants that he/she will comply with Jefferson Health - New Jersey's rules, policies, and procedures including the Jefferson Health - New Jersey Policy on Clinical Observers at Jefferson Health - New Jersey.
- c.** Unless specifically approved through the Jefferson Health - New Jersey Office of Medical Affairs, Clinical Observer represents and warrants that he/she will not directly or indirectly physically touch patients, will in no way interfere with the provision of healthcare in Jefferson Health - New Jersey and, will not perform medical history and/or examinations, counseling (patients or patient's family or friends), assist in surgery or any other procedure, or otherwise interact with patients, either individually or in the presence of others.
- d.** Clinical Observer represents and warrants that he/she will not photograph, audiotape, videotape, or otherwise record any aspect of the surgical procedure or recovery unless expressly permitted pursuant to a Jefferson Health - New Jersey policy.

- e. Clinical Observer represents and warrants that he/she will respect the privacy of all patients.

The parties consent to the terms of these Terms and Conditions.

6. Restrictions Observing is restricted from the following areas:

- a. Labor and Delivery
- b. Behavioral Health
- c. NICU
- d. Endoscopy Suite
- e. ICU (unless a student who is observing is enrolled in a formal medical training program and is shadowing under the terms of an affiliation agreement and at the discretion of the Kennedy University Hospital preceptor).
- f. Operating Room (individuals who want to shadow in the OR must successfully complete the process as outlined above AND interview with the Chief of Surgery and complete the OR orientation. No more than three individuals shall be approved for shadowing in the hospital OR's during the same time period.)



STATEMENT OF AGREEMENT

I agree to conform to all hospital policies and procedures during the time I spend at Jefferson Health New Jersey Division. I agree to take direction from the designated program professional and his/her designees.

I understand that for my safety and the safety of the patients in this healthcare setting it is important for me to supply all required medical and background check documentation prior to starting the shadowing experience.

I understand that despite all reasonable safety precautions, healthcare environments present a risk of exposure to communicable diseases. I agree to abide by the Standard Precautions procedures and stated policies of Jefferson New Jersey.

I understand that emergency medical assistance is available if needed but that I am responsible for any related expenses and for my own health insurance.

I understand that the Health System has the right to terminate my shadowing at any time, and that I have no right to participate (touch patients, treat, etc.) in patient care. I understand that the Health System is not providing insurance coverage for me, including professional liability or general liability insurance.

In consideration for the opportunity to complete my experience at Jefferson Health New Jersey Division, I hereby release Jefferson Health New Jersey Division, its officers, director, trustees, Central Governing Board and members, employees, and agents from any claim, damage or liability related to my experience at Jefferson Health New Jersey Division.

Date: _____

Signature _____



General HIPAA Privacy Statement

I understand and agree that it is my responsibility to maintain confidentiality for all patients using services at Jefferson Health New Jersey. The Health Insurance Portability & Accountability Act (HIPAA) Privacy Rules ensure our patients' expectations that private health information remain confidential and that only employees and volunteers with a "**need to know**" access their information to get the job or assignment done. I understand that protecting the confidentiality of patient information includes protecting both the patient's personal identity and the patient's health related information.

I understand that any use, sale, barter, or disclosure of confidential patient information for purposes outside of the scope of my service at Jefferson Health New Jersey is prohibited, and that such disclosures may also be in violation of state or federal law. Violating confidentiality outside of the scope of my service may lead to loss of my shadowing opportunity and potential personal liability for civil or criminal penalties.

Print Name

Signature

Date

Requirements Prior to Start Date

- _____ Completed Clinical Observer Agreement
- _____ Confidentiality Agreement (Page 2, Section 5)
- _____ Copy of COVID19 Vaccination Card
- _____ Copy of Driver's License
- _____ Criminal Background Check
- _____ Official U.S. College Transcript or Verification of Current Enrollment in a U.S. Higher Education Program
- _____ Copy of N-95 Respirator Fit Testing Results
- _____ Flu Documentation (If rotation is between September and February)
- _____ Copy of Health Insurance Card
- _____ Proof of Liability Insurance (May be homeowners or rental insurance)
- _____ Immunization Records Including negative TB Screen (To be read within 12-month period)

Clinical Observer	Supervising Physician (Observer must obtain)
_____ (Print Clinical Observer's name)	_____ (Print Supervising Physician's name) _____ (Print Supervising Physician's title)
_____ (Clinical Observer's Signature)	_____ Supervising Physician's Signature
Date: _____	Dept: _____

OBSERVER IMMUNIZATION DOCUMENTATION

NAME: _____ GENDER: Male Female
DATE OF BIRTH: _____ TIME PERIOD OF YOUR VISIT: _____
ADDRESS: _____ CELL PHONE: _____

EMAIL: _____

THE FOLLOWING INFORMATION IS REQUIRED. INCOMPLETE FORMS WILL DELAY YOUR START DATE.

Immunization Status (check one on each line).

- Measles: Up-to-Date on Immunizations Had Disease Unknown
Mumps: Up-to-Date on Immunizations Had Disease Unknown
Rubella: Up-to-Date on Immunizations Had Disease Unknown
Varicella: Up-to-Date on Immunizations Had Disease Unknown
Hepatitis B: Up-to-Date on Immunizations Declined Vaccine at School
Tuberculosis: Negative PPD on _____ Negative CXR on _____