Visiting Resident Orientation Checklist

I have read the material in the Visiting Medical Student Orientation Packet and have contacted the VSA Office with any questions. I understand that I am personally and professionally responsible for its content.

This packet includes the following information:

1. Overview of Carilion Clinic
2. Ethical Treatment of Patients
3. Customer Service
4. Carilion Scorecard
5. General Safety
6. Emergency Codes
7. National Patient Safety Goals
8. Event Reporting
9. Biomedical Ethics Services
10. Electrical Safety
11. Infection Control
12. Hand Washing
13. Communicable Diseases and Isolation
14. Confidentiality
15. HIPAA Security and Privacy Awareness
16. Disaster Plan
17. Workplace Harassment
18. Corporate Compliance Program

I have read the above and contacted my director with any questions.

Signature	Last 4 of SSN	Date (MM/DD/YY)	Print Your Full Name

Permitted Use of Carilion Clinic's EMR

- Residents may access the EMR only when they are physically on site at a Carilion Clinic facility and from a Carilion-networked computer.
- Residents may access the EMR off-site ONLY IF they 1). are actively participating in an approved clinical rotation at the time of access and 2). are in a private area—NOT from a public location.
- Residents may access only the medical records of patients for whom they are caring at the time of access.
- Resident access is monitored and violations are reported to both Carilion Clinic and the resident's school.
- Residents may not take or print any HIPAA-protected information in Carilion Clinic's EMR.
- Residents are not permitted to utilize or discuss any HIPAA-protected information they obtain from an EMR for a non-clinical or non-authorized reason.
- If a resident violates this Permitted Use Statement, immediate termination from participation in clinical rotations at any Carilion Clinic facility will occur.

I have read the above requirements and understand that I must comply with them in order to participate in a clinical rotation at Carilion Clinic. I further understand and agree that if I violate any of the above requirements, I will immediately be terminated from participation in clinical rotations at Carilion Clinic. In addition, I recognize that loss of the privilege of participating in a clinical rotation at Carilion Clinic will have a negative impact on my student and professional career in healthcare.

Signature	Last 4 of SSN	Date (MM/DD/YY)	Print Your Full Name

CARILION CLINIC

Access & Confidentiality Agreement

I am a member of one of the following groups which has access to Confidential Information of Carilion Clinic and/or its affiliated companies ("Carilion") and need to be aware of and abide by the laws and policies that apply to confidential information:

- Carilion employees;
- Business Associates;
- Physicians or employees of physicians;
- Sales Representatives;
- Committee Members;
- Board Members;
- Students / Residents
- Volunteers; and
- Contracted employees and their employees

Confidential information is protected both by law and strict Carilion policies. The intent of these laws and policies is to assure that confidential information is accessed and shared only to the extent necessary and appropriate in the performance of job-related duties.

Confidential information is defined as anything that is expected to remain private by us or those individuals with whom we interact and includes information relating to:

a. patients and plan members (such as medical records, photographs, video images, conversations, admitting information, diagnosis, test results, patient financial information, etc.);
b. employees (such as salaries, employment records, disciplinary actions, etc.);
c. Carilion (such as financial and statistical records, strategic plans, internal reports, peer review information, business practices, software and documentation developed by individuals for Carilion, etc.);
d third parties (such as provider and payor contracts, client and vendor agreement information, software and documentation developed for or used by Carilion, etc.); and
e. providers (such as medical records, credentialing information, malpractice or disciplinary actions, financial or business records)

Confidential information may be used only as needed to perform my specific job or activity related responsibilities. Access to confidential information is subject to periodic review, revision, and, if appropriate, renewal.

As an employee, affiliate or other group member of Carilion, I am required to comply with the laws and Carilion policies and guidelines relating to confidential information. I understand that:

1. I may have access to confidential information and I am responsible for protecting all confidential information.
2. Confidential information may only be used as needed to perform my specific job responsibilities or assigned activities. I may:
   a) only access confidential information for which I have a need to know;
   b) not disclose, copy, release, sell, loan, review, alter or destroy any confidential information except in the scope of my regular job responsibilities or assigned activities;
   c) not share or disclose specific patient health information or specific provider information with anyone other than those persons within or outside the organization authorized to see such information;
   d) not misuse or be careless with confidential information;
   e) not take photographs or video taped views of patients or patient family members unless it is directly related to my job; and
   f) only access the minimum necessary clinical or demographic protected health information (PHI) to perform my job responsibilities or other assigned activities.
3. Carilion may revoke my access codes, other authorization or access to confidential information at any time.
4. **I must safeguard and not disclose or share my access codes, passwords**, or any other authorization I have that allows me to access confidential information. I understand I am responsible for all activities undertaken using my access codes, passwords, or other authorizations.
5. I will report to the Privacy Officer, (540) 981-7751, or my site risk manager, activities or individuals that I suspect may compromise the confidentiality of information.
6. I have no right or ownership interest in any confidential information referred to in this Agreement.
7. My obligations under this Agreement will continue after separation from employment with Carilion.
8. Violating this Agreement or Carilion's confidentiality policy and guidelines will subject me to corrective action, which may include:
   a. loss of access to information;
   b. Loss of privileges at Carilion;
   c. Separation of my employment;
   d. legal liability; and
   e. civil or criminal penalties or monetary fines

I understand that I am not allowed to use my Carilion authorized access to health information or demographics including addresses or birthdays, about my co-workers, other employees, friends, neighbors, or family members unless the information is needed to perform my job responsibilities. Specifically, as it relates to getting personal information about my family members or others, I understand that I am required to use the same process used by non-employees which is to go to Health Information Management (Medical Records) and sign an authorization form. Should I have access to my own health information (electronic or hard copy) in accordance with Carilion policy, I am not allowed to modify my own medical record nor create, authorize or sign my own prescriptions. If I have a specific need for health information, I will work with my manager and the Corporate Privacy and Information Security Officer for access.

By signing below, I acknowledge that I have read and understand the above Agreement and agree to abide by the terms of this Agreement and the confidentiality policy and guidelines as established by Carilion Clinic.

☐ Employee
☐ Non-employee, Student

Print Name: _____ Date: _____

Signature: _____ _____
Last 4 digits of your SSN

Revised: 02152013

CARILION CLINIC

Participation Agreement

I am participating in various practical, clinical, and/or observational experiences (Education Experience) either (i) through a school which has entered into a Student Program Agreement to do observation or clinical participation with the Provider, or (ii) through an independent Educational Experience approved and accepted by the Provider pursuant to this Agreement.

Policies and Procedures: In consideration of my acceptance into said Educational Experience, I understand and agree that while participating in the Educational Experience, I am subject to all of the Provider's rules, policies and procedures, including those relating to appearance and behavior. I further understand and agree that I may be required to withdraw from the Educational Experience if my performance is unsatisfactory; or if I fail to comply with said rules, policies, and procedures; or if my health status, taking into account all reasonable accommodations, is a detriment to my successful completion of the Educational Experience.

Confidentiality: I understand and agree that the services the Provider performs for its patients and the information patients furnish to it are highly confidential. It is the Provider's obligation and policy to protect the patient's right to privacy and to maintain the confidentiality of all patient medical records, including the identity of patients, the services performed for them, and all information concerning their affairs (hereafter referred to as the "Patient Information"). Provider's good will depends upon, keeping such patient information confidential.

In addition to Patient Information, I acknowledge that the Provider's operation, policies, procedures and records constitute important business assets and are confidential. Such records include, but are not limited to personal records, strategic plans, policy and procedure manuals, bookkeeping and other accounting information, and all such documents and records related to Provider's business activity (hereinafter referred to as "Business Information").

By reason of my participation in the Educational Experience, I may come into possession of Patient Information or Business Information. I understand and agree that the Patient Information and Business Information obtained by me during my participation in the Educational Experience shall not be revealed to anyone without the signed written authorization from the patient or guardian in the case of Patient Information or from the Provider in the case of Business Information. I agree not to permit anyone to examine or make copies of any Patient Information or Business Information that may come into my possession.

Assumption of Risks: As a participant in the Educational Experience, I may be allowed to observe or, where applicable to the Educational Experience, participate in clinical activities in patient care areas, including high risk patient care areas such as the Emergency Department or Adult Special Care Units. I understand that in such high-risk patient care areas that Provider's policies may restrict my activities and observation may be limited to certain specified areas.

I understand that there are risks and hazards associated with participating in the Educational Experience in a health care setting, particularly in circumstances where I am permitted in high-risk patient care areas. Further, I understand that in spite of appropriate precautions, there are risks of infections and contradicting communicable diseases. Also if I do not use proper care and follow directions given to me, I may injure others or myself or cause damage to my property or the property of others. By participating in the Educational Experience, I agree to assume such risks, including the added risks associated with high-risk patient care areas. I agree to accept responsibility for my own actions and not to hold Provider responsible for such actions. I will not seek damages or other compensation from Provider for any injuries to me or my property, unless such injuries are caused by the gross negligence or willful misconduct of the Provider, its employees or agents, nor will I ask the Provider to pay for any injuries that I might cause to others or the property of others, including Provider's property, except to the extent that such injuries are not covered by my insurance, but are covered by the Provider's insurance.

Binding Agreement: I acknowledge that I have read this Agreement and that I understand and agree that any violation of this agreement may involve violations of state and federal laws and regulations governing the patient's right to privacy or the right of a company to maintain the confidentiality of its business records. I recognize that the disclosure of information by me may give rise to irreparable injury to you or your patients and that you or your patients may seek any legal remedies against me that may be available in the event of such disclosure.

Signature	Last 4 of SSN	Date (MM/DD/YY)	Print Your Full Name

Print Form