HENRY FORD
MACOMB HOSPITALS

HENRY FORD MACOMB HOSPITALS
CLINICAL/NON-CLINICAL EXPERIENCE PARTICIPATION AGREEMENT

I, _____ ("Student"), in consideration of participating in the clinical/non-clinical education program provided by HENRY FORD MACOMB HOSPITALS ("Agency"), through my participation in Agency's clinical/non-clinical training program, hereby agree to the following:

1. I will comply with all applicable standards of care, policies, procedures, rules and regulations of Agency, including Joint Commission, including but not limited to, those governing patient confidentiality. I understand that the foregoing information is available on Agency's website and acknowledge that I have been directed to such to learn of my obligations. The web address is http://henry.hfhs.org/. I will further observe conservative and professionally appropriate modes of dress, behavior and grooming at all times. I will wear my Student identification badge at all times, and will return it to the faculty at the end of my Student experience.

2. I will participate in clinical/non-clinical education and training opportunities in accordance with the instructions of Agency supervisors.

3. That I meet the health requirements set forth in this paragraph and I will provide, upon request, satisfactory evidence of a negative Mantoux TB skin test within the past twelve months or, if a Mantoux TB skin test is contraindicated, a recent negative symptom assessment for active TB within the past twelve months with a baseline chest x-ray, and evidence of rubeola, mumps, rubella, and varicella zoster vaccination or antibody titer, seasonal influenza vaccination, hepatitis B vaccination (or written refusal of hepatitis B vaccination signed by the Student that expressly holds Agency harmless for any hepatitis B exposure or infection that may result from the Student's clinical/non-clinical experience at Agency) and/or such other immunization and health-related testing as may be required by the Michigan Department of Community Health (previously known as Michigan Department of Public Health) or the Occupational Health and Safety Administration for each Student assigned to Agency, as these requirements may change from time to time. I understand that if I refuse any immunizations or health-related testing, I may be terminated from the clinical/non-clinical education program at Agency. In the event, however, that I refuse the hepatitis B vaccination, I will not be terminated from the Program if I promptly sign a written waiver expressly holding Agency harmless for any hepatitis B exposure or infection that might result from clinical/non-clinical experience at Agency. I understand that the Agency is not financially or otherwise responsible in the event that I am exposed to blood, body fluid, or a communicable disease or am injured in any way.

4. CPR Certification. I will provide, upon request, evidence of current CPR card before clinical/non-clinical rotations begin.

5. Student and Faculty Drug Information. I authorize the School, without liability on their part, to disclose to Agency any information on me within the School's knowledge or possession of drug testing or drug use.

6. Student and Faculty Criminal Background Investigation. I will submit to a criminal background investigation of a scope and within time periods satisfactory to the Agency and will ensure that the results of said investigations are sent directly from the investigator to the School where they will be maintained. School coordinator will meet with the Agency's coordinator before a new clinical/non-clinical rotation begins for the purpose of determining whether each faculty member or student, based on the results of said investigation and the good-faith determination of both parties, is disqualified for placement at Agency.

7. Confidentiality. Due to the services performed at Agency, the School and Student, pursuant to this Agreement, are subject to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). As such, School and Student agree to the following obligations with respect to the functions or activities involving the use or disclosure of individually identifiable health information:

a) Protected Health Information. In the course of performing the duties and obligations under this Agreement, School and student will receive or create certain information concerning patients or clients of Agency that constitute Protected Health Information (PHI) with the meaning of HIPAA.

b) Obligations of School and Student with respect to PHI. School and student agree that s/he will:
i) Not use or further disclose PHI, other than as required by law; and
ii) Use appropriate safeguards to prevent the use or disclosure of PHI, other than as provided for in this Agreement; and
iii) Comply with the privacy policies of Agency in effect and as changed from time to time.

8. I understand and acknowledge that Agency has the right to take certain actions, including but not limited to, the right to suspend or terminate me from, or limit my participation in, the clinical/non-clinical education program, or to evaluate me unfavorably, if in its exclusive judgment I have failed to observe applicable policies, procedures, rules, regulations, or the instructions of Agency supervisors, or have compromised the standard or quality of patient care or the safety of patients, or for other reasonable cause, including the failure to follow appropriate modes of dress, grooming and behavior. I hereby voluntarily release Agency and their employees, agents and medical staff from any and all liability based on such actions.

9. I acknowledge that the clinical/non-clinical experience received by me from Agency shall be received as a Student of the School, as a part of my professional training, and not as an employee of Agency. I understand that as a participant in this clinical/non-clinical education program, I shall not be entitled to compensation or employee benefits, nor shall I be considered an employee of Agency for purposes of unemployment compensation, minimum wage laws, workers' compensation, income tax withholding, Social Security, or any other purpose.

10. I understand and acknowledge that the School shall have complete control over all academic aspects of the Program, including but not limited to, admissions, administration, faculty appointments, program design, grading, examinations and evaluations. I hereby voluntarily release Agency and their employees, agents and medical staff from any and all liability based on such actions.

11 I have read this Participation Agreement carefully and have had sufficient opportunity to ask questions and have it explained to me before signing it.

12. This Agreement will be valid if executed in two or more counterparts, with each counterpart constituting a single original and transmitted in person or electronically through facsimile, scan or e-mail. The parties agree that a printout of the scanned executed version of this document may serve as the original of this writing. The electronically stored copy of this Agreement is considered to be the true, complete, valid, authentic and enforceable record, admissible in judicial, administrative or arbitration proceedings to the same extent as if the documents and records were originally generated and maintained in printed form. The parties agree to not contest the admissibility or enforceability of this electronically stored copy of such documents in any proceeding between the parties.

_____ _____

Participant's Signature Date

_____ _____

Participant's Printed Name Phone No.

HENRY FORD MACOMB HOSPITALS
CONFIDENTIALITY AND NETWORK ACCESS AGREEMENT - STUDENT

The following rules for Confidentiality and Network Access apply to all non-public patient and business information (Confidential Information) of Henry Ford Macomb Hospitals and related organizations. The rules also apply to the non-public and business information of joint ventures, or of other entities and persons collaborating with Henry Ford Macomb Hospitals, to which the user has access. As a condition of being permitted to have access to Confidential Information relevant to my job function or role I agree to the following rules:

1. **Permitted and required access, use and disclosure:**
   - I will access, use or disclose Confidential Patient Information (PHI) only for legitimate purposes of diagnosis, treatment, obtaining payment for patient care, or performing other health care operations functions permitted by HIPAA and I will only access, use or disclose the minimum necessary amount of information needed to carry out my job responsibilities.
   - I will access, use or disclose Confidential Business Information only for legitimate business purposes of Henry Ford Macomb Hospitals or related entities.
   - I will protect all Confidential Information to which I have access, or which I otherwise acquire, from loss, misuse, alteration or unauthorized disclosure, modification or access including:
     - making sure that paper records are not left unattended in areas where unauthorized people may view them;
     - using password protection, screensavers, automatic time-outs or other appropriate security measures to ensure that no unauthorized person may access Confidential information from my workstation or other device;
     - appropriately disposing of Confidential Information in a manner that will prevent a breach of confidentiality and never discarding paper documents or other materials containing Confidential Information in the trash unless they have been shredded
     - safeguarding and protecting portable electronic devices containing Confidential Information including laptops, smartphones, PDAs, CDs, and USB thumb drives.
   - I will disclose Confidential Information only to individuals, who have a need to know to fulfill their job responsibilities and business obligations.
   - I will comply with Henry Ford Macomb Hospitals/Henry Ford Health System access and security procedures, and any other policies and procedures that reasonably apply to my use of the computer systems and/or my access to information on or related to the computer systems including off-site (remote) access using portable electronic devices.

2. **Prohibited access, use and disclosure:**
   - ***I will not access, use or disclose Confidential Information in electronic, paper or oral forms for personal reasons, or for any purpose not permitted by Henry Ford Macomb Hospitals, including information about co-workers, family members, friends, neighbors, celebrities, or myself. I will follow the required procedures at Henry Ford Macomb Hospitals to gain access to my own PHI in medical and other records.***
   - I will not use another person's, login ID, password, other security device or other information that enables access to Henry Ford Macomb Hospitals computer systems or applications nor will I share my own with any other person.
   - I understand that printing of materials containing the Protected Health Information (PHI) of patients or business information related to the health system is strongly discouraged. If I have possession of printed confidential information it will remain in my direct possession at all times on and off of the campus where I work. When these documents are no longer required I will destroy them in a manner that insures they are rendered indecipherable.
   - If my employment or association with Henry Ford Macomb Hospitals/Henry Ford Health System ends, I will not subsequently access, use or disclose any Henry Ford Macomb Hospitals/Henry Ford Health System Confidential Information and will promptly return any security devices and other Henry Ford Macomb Hospitals'/Henry Ford Health System property.
   - I will not engage in any personal use of Henry Ford Macomb Hospitals computer systems that inhibit or interfere with the productivity of employees or others associated with Henry Ford Macomb Hospitals'/Henry Ford Health System's operations or business, or that is intended for personal gain;
   - I will not engage in the transmission of information which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive,
     inappropriate or in violation of the mission, values, Code of Conduct, policies or procedures of
     Henry Ford Macomb Hospitals/Henry Ford Health System;
   - I will not utilize the Henry Ford Macomb Hospitals network to access Internet sites that contain content that is inconsistent with the mission, values and policies of Henry Ford Macomb Hospitals/Henry Ford Health System.

HENRY FORD MACOMB HOSPITALS
CONFIDENTIALITY AND NETWORK ACCESS AGREEMENT - STUDENT

3. Accountability and sanctions:

- I will immediately notify the Henry Ford Macomb Hospitals Security Official or Privacy Official if I believe that there has been improper/unauthorized access to the Henry Ford Macomb Hospitals network or improper use or disclosure of confidential information in electronic, paper or oral forms.
- I understand that Henry Ford Macomb Hospitals will monitor my access to, and my activity within, Henry Ford Macomb Hospitals computer system, and I have no rightful expectation of privacy regarding such access or activity.
- I understand that if I violate any of the requirements of this agreement, I may be subject to disciplinary action, my access may be suspended or terminated and/or I may be liable for breach of contract and subject to substantial civil damages and/or criminal penalties.
- If I lose my security device I will report the loss to the Henry Ford Macomb Hospitals' Information Security Officer immediately and I may be charged for its replacement.

4. Software use:

- I understand that my use of the software on Henry Ford Macomb Hospitals' network is governed by the terms of separate license agreements between the Henry Ford Health System and the vendors of that software.
- I agree to use such software only to provide services to benefit Henry Ford Macomb Hospitals.
- I will not attempt to download, copy or install the software on any other computer.
- I will not make any change to any of Henry Ford Macomb Hospitals'/Henry Ford Health System systems without prior express written approval from the Information Technology department.

5. Network:

- I understand that access to Henry Ford Macomb Hospitals' network is "as is", with no warranties and all warranties are disclaimed by Henry Ford Macomb Hospitals.
- Henry Ford Health System may suspend or discontinue access to protect the network or to accommodate necessary down time. In an emergency or unplanned situation HFHS may suspend or terminate access with out advance warning.
- Henry Ford Macomb Hospitals/Henry Ford Health System may terminate this agreement, user access and use of Confidential Information at any time for any reason or no reason.

SIGNATURE
RELATIONSHIP TO HENRY FORD MACOMB HOSPITALS

I am: (Please check all that apply to you)

Direct relationships with Henry Ford Macomb Hospitals

___Clinton Township Campus ___Mt. Clemens Campus ___Satellite

___Employee

___Physician Credentialed on the Medical Staff

___Volunteer

___Temporary/Contractor: (name of agency): _____

___Student (name of educational organization):_____

USER SIGNATURE

If there are any items in this agreement that I do not understand I will ask my Henry Ford Macomb Hospitals supervisor or other appropriate Henry Ford Macomb Hospitals contact person for clarification. My signature below acknowledges that I have read, understand and accept this agreement and realize it is a condition of my employment or association with Henry Ford Macomb Hospitals. I also acknowledge that I have received a copy of the Confidentiality and Network Access Agreement.

_____
Print Name

_____
Signature of individual to be given access Date

Henry Ford Macomb Hospitals

Acknowledgment of Student Obligations

By my signature below, I acknowledge receipt of Henry Ford Macomb Hospitals' Orientation Packet and that I have read, understand, and agree to abide by the all the Student obligations set forth in the Orientation Packet.

Student's Signature _____ Date _____

Student's Printed Name _____ School / Program Name _____

School Instructor (if applicable) _____

Complete the following if you are a student **NOT** placed through the ACE MAPP System.

PLEASE PRINT:

Address _____ City, State, ZIP _____

Email Address _____

School _____ Program Name _____

Instructor (if applicable) _____ Preceptor (if applicable) _____

Placement Site Location / Department / Unit _____