INTERNSHIP/CLINICAL EXPERIENCE OPPORTUNITY REQUEST

Providence Medical Center 1200 Providence Rd. Wayne, NE 68787

Last Name:	First Name: Middle Initial:
Home Address:	License Plate State and Number:
City, State, Zip:	
Home Phone:	Cell Phone:
E-mail:	Date of Birth:
Name of School: Year in School:	
If you are under 19 please list name and contact information for parent/legal guardian. Parental/Guardian signature will be required on training documentation and they are encouraged to attend training with student.	
Name:	
Relationship:	Contact #:
Occupation or department you want internship/clinical experience in:	
Briefly describe your reason for wanting a job internship, including learning and career objectives, number of hours you want to intern, observational requirements, etc.	
What date(s) and time(s) are you available for your internship?	
Emergency Contact Name (1):	
Relationship:	Phone:
Emergency Contact Name (2):	
Relationship:	Phone:
Do you have any limitations or special needs which need accommodation? Explain:	
Have you ever volunteered or been employed by Providence Medical Center? If yes, when?	
Have you ever been arrested or convicted of a crime? List dates and charges.	
The information provided on this application is true and complete to the best of my knowledge. I have read the self-study orientation.	
Date:	Signature:

Providence Medical is an Equal Opportunity Employer and Provider

****Return this form to Human Resources. HR can be reached at 402.375.3800 or hr@providencemedical.com****

Confidentiality Agreement for Student Experience

Confidentiality is a major concern of patients in a medical facility. Providence Medical Center expects its employees, volunteers, contracted employees and anyone involved in any kind of educational experience to respect the privacy of its patients. Any information, operation or incident observed or heard while at Providence Medical Center must be kept in strictest confidence. Any breach of confidentiality will result in automatic and immediate expulsion of an individual from the educational experience.

An individual involved in an educational experience at PMC is expected to exhibit a professional attitude and behavior while on the premises. They must obey the rules and regulations of this institution and any instructions given to them by their mentor. Providence Medical Center reserves the right to require safety in-service at no cost to the individual if it is deemed necessary.

The Federal Health Insurance Portability Accountability Act (HIPAA) Privacy Law governs the release of patient identifiable information by hospitals and other health care providers. This law establishes protections to preserve the confidentiality of various medical and personal information and specify that such information may not be disclosed except as authorized by law or the patient or individual.

Confidential Patient Care Information includes: Any individually identifiable information in possession or derived from a provider of health care regarding a patient's medical history, mental, or physical condition or treatment, as well as the patients and/or their family members records, test results, conversations, research records and financial information. Examples include, but are not limited to:

• Physical medical and psychiatric records including paper, photo, video, diagnostic and therapeutic reports, laboratory and pathology samples;

• Patient insurance and billing records;

• Mainframe and department based computerized patient data and alphanumeric radio pager messages;

• Visual observation of patients receiving medical care or accessing services; and

• Verbal information provided by or about a patient.

Confidential Employee and Business Information include, but are not limited to, the following:

• Employee home telephone number and address;

• Spouse or other relative names;

• Social Security number or income tax withholding records;

• Information related to evaluation of performance;

• Other such information obtained from PMC's records which if disclosed, would constitute an unwarranted invasion of privacy; or

• Disclosure of Confidential business information that would cause harm to Providence Medical Center.

CONFIDENTIALITY STATEMENT

I understand and acknowledge that:

1. I shall respect and maintain the confidentiality of all discussions, deliberations, patient care records and any other information generated in connection with individual patient care, risk management and/or peer review activities.

2. It is my legal and ethical responsibility to protect the privacy, confidentiality and security of all medical records, proprietary information and other confidential information relating to Providence Medical Center, including business, employment and medical information relating to our patients, members, employees and health care providers.

3. I shall only access or disseminate patient care information in the performance of my assigned duties and where required by or permitted by law, and in a manner which is consistent with officially adopted policies of Providence Medical Center, or where no officially adopted policy exists, only with the express approval of my supervisor or designee. I shall make no voluntary disclosure of any discussion, deliberations, patient care records or any other patient care, peer review or risk management information, except to persons authorized to receive it in the conduct of Providence Medical Center affairs.

4. Providence Medical Center performs audits and reviews patient records in order to identify inappropriate access.

5. If provided to me, my user ID is recorded when I access electronic records and that I am the only one authorized to use my user ID. Use of my user ID is my responsibility whether by me or anyone else. I will only access the minimum necessary information to satisfy my job role or the need of the request.

6. I agree to discuss confidential information only in the work place and only for job related purposes and to not discuss such information outside of the work place or within hearing of other people who do not have a need to know about the information.

7. I understand that any and all references to HIV testing, such as any clinical test or laboratory test used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specifically protected under law and unauthorized release of confidential information may make me subject to legal and/or disciplinary action.

8. I understand that the law specially protects psychiatric and drug abuse records, and that unauthorized release of such information may make me subject to legal and/or disciplinary action.

9. My obligation to safeguard patient confidentiality continues after my termination of my educational experience at Providence Medical Center.

I hereby acknowledge that I have read and understand the foregoing information and that my signature below signifies my agreement to comply with the above terms. In the event of a breach or threatened breach of the Confidentiality Agreement, I acknowledge that Providence Medical Center may, as applicable and as it deems appropriate, terminate my educational experience at Providence Medical Center.

Print Name:____

Signature:____

Department: ____

Dated:______________________