



# Orientation Confirmation Community Clergy and Lay Visitors

Caregiver Name PRINT: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Welcome to Monument Health. We look forward to having you as part of our team. Below is a checklist of required online training that needs to be completed before performing work at any Monument Health Facility.

**Instructions:**

1. Please go to monument.health and search orientation (please see the Community Clergy and Lay Visitors Section for the information) to review the Safety Information for your role at Monument Health. The required courses are listed below.
2. You will need a computer with sound. If you don't have access to a computer with sound, please contact your Monument Health representative. *We request that you complete the presentations prior to your appointment with your Monument Health Representative.*
3. At the end of each presentation you will see a confirmation number. Please print the confirmation number below next to the course title.
4. After you have completed the courses required and the necessary paperwork, please sign the form at the bottom of the page. Please call Pastoral Services at (605) 755-8191 to schedule an appointment.
5. If you have any problems completing the presentation(s) or have any questions, please contact your Monument Health Representative.

### Orientation Presentations for Community Clergy and Lay Visitors

Title	Confirmation Number
Monument Health Compliance and HIPAA	
Monument Health Infection Control / Personal Protective Equipment (PPE)	
	<i>Please initial in box that you have reviewed</i>

**By initialing this document, I certify that I am in compliance with Monument Health's annual influenza vaccination policy and COVID-19 vaccination policy.** \_\_\_\_\_ Initial

**You will need to bring the following completed documents to your next scheduled appointment.**

- Orientation Confirmation Form     Confidentiality Agreement
- Badge Request     Required Paperwork Requested by your Monument Health Representative

**By signing this document, I certify that I have completed all training requirements, have read and agree to Monument Health's Confidentiality Agreement.**

Clergy / Lay Visitor Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

# Code of Conduct Attestation

I attest that:

- I have received the Monument Health Code of Conduct and understand that it is my responsibility to read and comply with the legal and ethical practices contained in the Code of Conduct.
- I will report potential compliance issues to management, medical staff leadership, the Corporate Responsibility Department at 605-755-9020, or the Compliance Hotline at 1-877-800-6907 or [secure.ethicspoint.com/domain/media/en/gui/62003/](https://secure.ethicspoint.com/domain/media/en/gui/62003/).
- I will uphold the values of the organization demonstrated by my conduct.

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PRINTED NAME

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SIGNATURE

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DATE

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TITLE OR POSITION

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FACILITY

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DEPARTMENT





# Confidentiality Agreement

Monument Health (MH) is committed to protecting the confidentiality and security of patients' protected health information (PHI) and MH's sensitive business information.

As a condition of my employment or other affiliation including medical staff, independent contractor, vendor, volunteer, intern, observer or student I am required to read, agree and comply with terms of this agreement. Nothing in this agreement shall prohibit employees from engaging in protected concerted activity permitted by the National Labor Relations Act § 7 (29 U.S.C §157).

PHI is information in any form (e.g. electronic, written, and spoken/heard) that can be used to identify a patient including demographic information (e.g. patient name), financial information (e.g. insurance company) and health information (e.g. diagnosis code, x-ray). MH's sensitive business information includes, but is not limited to: 1) business plans or financials of any MH facility; 2) employee or job applicant information; 3) peer review or quality of care information or 4) passwords.

My disclosure of confidential information may cause irreparable injury to an individual, and/or to MH, which might result in civil action against me by harmed individuals or entities. I understand MH's liability insurance might decline coverage for me in the event I am sued for breaching confidentiality. I understand MH might refuse to indemnify me for the unauthorized disclosure of confidential information.

I understand I have a responsibility to protect the privacy and security of PHI and confidential information and I agree with the following:

- To follow MH policies and procedures regarding use and disclosure of PHI and confidential information.
- To take all reasonable precautions to safeguard confidential information. Some of these precautions include not sharing my password with others, locking or logging out of the computer when I leave, shredding documents that contain PHI and confidential information, turning over unattended documents that contain PHI and confidential information.
- To ask my supervisor if I have any questions about whether a use or disclosure of PHI and confidential information is permitted.
- To only request or access the minimum amount of information that I need to do my job. This does not include accessing my own, my family or my friends' medical records.
- To only discuss PHI and confidential information with individuals who need the information to do their job. I understand the presence of a patient/resident at a MH facility or ability to pay their bill is considered PHI and cannot be used or disclosed unless there is a "need to know."
- To recognize my surroundings and only discuss PHI and confidential information in an area where there is a low risk that individuals without a need to know may overhear. I will use a low voice when there is a possibility that an individual may overhear my conversation.
- To not discuss PHI and confidential information in public (e.g., social media, internet blogs, cafeterias, restaurants, social events) even if specifics such as names are not used.
- To use PHI and confidential information only in ways that could be interpreted as in the best interest of MH.
- If my employment or other affiliation with MH ends, I will immediately return all MH property (keys, documents, equipment, ID badges, etc.). I realize my obligations under this Agreement continue after the end of my employment or other affiliation. I will not share or speak about any information I learned while at MH.
- That I have a responsibility to report any potential privacy or security violations to my supervisor, director, the Corporate Responsibility Department or the Hotline.
- That violating any of the promises or representations made in this Agreement may result in corrective action, up to and including termination and/or suspension, restriction or loss of privileges, as well as potential personal civil and criminal legal penalties.

By my signature below, I certify I have read this Agreement, I have had the opportunity to ask questions, I understand the Agreement and I agree to be bound by its terms.

Caregiver Name PRINT: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Facility Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Please bring the following completed forms to the Monument Health Help Desk to have your badge processed.

Date of Badge Request: \_\_\_\_\_

Reason for Request: \_\_\_\_\_



Requestor's Information:

Employee ID or Last four digits of your Social Security Number: \_\_\_\_\_

#1 \_\_\_\_\_ #2 \_\_\_\_\_  
*First Name Last Name Middle Name*

Line #1 – You may indicate the common derivative of the name you normally go by (i.e., Bob, Ted, Beth, etc.). No nicknames will be allowed. Employees may indicate a middle initial, if they wish. A maximum of 14 characters may be used in this field.

Line #2 – The name shown on your hospital records will be displayed. Employees may elect to have only the first initial of their last name displayed. Supervisory Personnel, Department Managers and Administrators will have their entire last name displayed.

Line #3 – Please select what you will be employed as with Monument Health.

Line #4 – If you will be a contractor or vendor, please list the company where you are employed below.

Company Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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**For Monument Health Contact:**

MH Representative Name PRINT: \_\_\_\_\_ Department: \_\_\_\_\_

MH Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_