MONUMENT HEALTH

Orientation Confirmation
Job Shadowing Students

Job Shadowing Student 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 job shadowing at any Monument Health Facility.

Instructions:

1. Please go to monument.health and search orientation (please see the Job Shadowing Section for the presentations) to review the Code of Conduct Book 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. You will need to show proof of Flu vaccination. Flu shot only if required during flu season (usually late November thru March).
5. If you have any problems completing the presentation(s) or have any questions, please contact your Monument Health Representative.

Orientation Videos for Job Shadowing Students

Title	Confirmation Number
Monument Health Compliance, Ethics and Security Training 2024	
Reviewed Code of Conduct Book	*Sign Code of Conduct Attestation form at the back of the book*

You will need to email the following completed documents to studentinfo@monument.health:

☐ Orientation Confirmation Form ☐ Confidentiality Agreement

☐ Badge Request ☐ Code of Conduct Attestation ☐ Proof of Flu Shot for this season

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

Job Shadowing Student Signature: _____ Date: _____ Time: _____

School / College: _____

MONUMENT HEALTH

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: _____

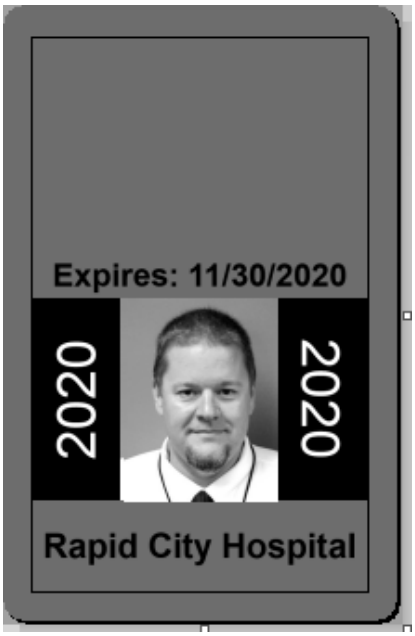
Caregiver Phone # *(Optional)* : _____ Caregiver Email *(Optional)*: _____

Facility Name: _____ Job Title:_____

MONUMENT HEALTH

Identification Badge Request

Please bring the following completed forms to the Monument Health Security Office to have your badge processed.



Date of Badge Request:_____

Reason for Request:

Renew

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.

Monument Health Employee

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

Company Name: _____ Phone Number: _____

For Monument Health Contact: Other (please specify):

MH Representative Name PRINT: _____ Department: _____

MH Representative 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/.
- I will uphold the values of the organization demonstrated by my conduct.

_____
PRINTED NAME

_____
SIGNATURE

_____
DATE

_____
TITLE OR POSITION

_____
FACILITY

_____
DEPARTMENT