Winneshiek MEDICAL CENTER | Physician services by MAYO CLINIC HEALTH SYSTEM

Shadow Student Orientation Acknowledgement

Student first and last name: _____

Please initial **each** line item you have reviewed in the WMC Orientation Packet.

Initial	Role of the Student at Winneshiek Medical Center
Initial	Mission, Vision and Values
Initial	Name Badge
Initial	Tobacco Free Campus
Initial	Parking
Initial	Timeliness / Attendance
Initial	Background Screening
Initial	Conduct and Behavior
Initial	Alcohol and Drugs
Initial	Phones and Mobile Devices
Initial	Dress Code, Tattoos, and Personal Hygiene
Initial	Customer Service / Courtesy
Initial	Covid Vaccination Proof
Initial	Diversity and Inclusion and Language Services
Initial	General Safety, including Preventing Falls, Abuse Reporting, and Incident Reports
Initial	Fire Safety
Initial	Safety Codes
Initial	Infection Control, Hand Hygiene and Hand washing Procedures
Initial	Blood Borne Pathogens and Standard Precautions
Initial	Immunizations and Flu shot requirement
Initial	Personal Illness Reporting and Student Health Agreement
Initial	Confidentiality, Privacy, and HIPAA
Initial	Covid Vaccine requirement for all student experiences understood
Initial	Immunizations and Covid proof attached
Initial	Signed Confidentiality form attached (with parent / guardian signature if under 18)
Initial	I understand that this orientation packet is valid for the current school year. If I shadow again after June 30, I will need to repeat this orientation and provide new paperwork to Winneshiek Medical Center.

****What was the image of at the end of the orientation program that you were asked to remember?**
This is how we know you completed the orientation.

By signing this document, I agree that I have reviewed and understand the expectations, policies and procedures included in the student orientation on the above topics.

_____
Student Signature Date

RETURN THIS FORM TO education@winmedical.org or fax to 563-382-1962 Rev 03302022

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STUDENT INFORMATION SHEET – SHADOW STUDENT

Name: _____ **Today's Date:** _____

JOB ROLES REQUESTED: _____ **DOB:** _____

DATES / DAYS OF WEEK / TIMES AVAILABLE: _____

Email Address (required): _____ **Cell Phone Number:**_____

Address: _____**City:** _____ **State:** _____ **Zip:**_____

Emergency Contact: _____ Relationship:_____ Phone#_____

School (if applicable): _____

_____ Photo identification – attach to email (school photo ID or driver's license)

IMMUNIZATIONS: The safety of our staff, patients and guests is important to us. *Please provide record of your immunizations with this packet.* ◯

Additional to Covid vaccine and booster proof, annual Flu vaccine is required for shadow students during the influenza season from November 1 – March 31. Shadows will be scheduled after two weeks following student flu shot.

Minor Guardian Signature: We, the responsible guardian(s), have reviewed the policies, procedures, and expectations for this student experience. We are especially aware of the confidentiality requirements that must be adhered to while working with patients, visitors, and information. This confidentiality agreement is in effect indefinitely after the experience is completed. We have discussed the importance of these expectations together as guardian and child, and agree to adhere to the expectations. I authorize them to participate in this experience. Neither Winneshiek Medical Center, Mayo Clinic Health System, nor its staff shall be held responsible for adverse occurrences and/or outcomes as a result of this experience. Should my child need medical attention during and/or as a result of this experience, I authorize such medical care, and assume full responsibility for any treatments deemed necessary. I assume responsibility for all medical costs which result and release the facility of all liability.

Guardian Signature: _____ Date: _____

(if student is under the age of 18)

OFFICE VERIFICATON

	Number of Hours for Shadow (office use only)

DATES / TIMES SCHEDULED:

OTHER WMC Notes:

_____ Ticket to Ride sent

CONFIDENTIALITY AGREEMENT

All WMC personnel including employees, volunteers, students, contracted services and medical staff will demonstrate an understanding and commitment to the protection of patient privacy and the confidentiality and security of health information.

- ✓ I understand that the right of confidentiality applies to all patients and that all patient information is confidential (not just diagnosis and treatment)
- ✓ I understand that not all WMC employees are permitted access to patient records.
- ✓ I understand that persons who access patient information and other confidential data must have a legitimate reason (i.e. patient care or administrative audit) to know the information as it relates to their job function.
- ✓ I understand that elevators and other public areas are inappropriate places to discuss patient information and other confidential data even if a patient's name is not used. Such conversations may raise doubts among patients and visitors about our respect for their privacy.
- ✓ I am aware of the precautions and mechanisms used in my home department to safeguard confidential information including computer access, workstations and discussion. I will log off any computer or terminal prior to leaving it unattended.
- ✓ I understand that I am obligated to report security and privacy violations immediately to my supervisor or the compliance officer and when possible I will stop the security/privacy violation.
- ✓ I understand that my obligation under this competency continues after the termination of my employment.
- ✓ I understand that patients have a right to know how their health information is used and that patients must authorize the disclosure of their information except when the disclosure is required by law.
- ✓ I understand that patients have the right to restrict disclosure of their health information.
- ✓ I understand that patients have a right to recommend amendments and or request correction to their medical records.
- ✓ I understand that patients must specifically authorize the disclosure of information related to substance abuse, mental health, and HIV/AIDS.
- ✓ I will forward requests for health information to Health Information Management for appropriate processing, including facsimile requests, walk-in, telephone, etc.
- ✓ I will direct all medical record subpoena/court order requests to the Director of Health Information Management.
- ✓ I understand that all students and volunteers who have access to any information about patients will receive written orientation instructions regarding confidentiality and patient privacy prior to accessing such information.
- ✓ I understand that WMC considers intentional and unintentional breaches of patient information a very serious matter. Violations to security and privacy policies will result in appropriate disciplinary actions up to and including termination.
- ✓ I understand that by signing this document that I am agreeing to comply with the above terms.
- ✓ I confirm acknowledgement and receipt of the WMC policies and training related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- ✓ I confirm that I am expected to understand and follow policies and procedures related to HIPAA completely. If concerns or questions arise, I may contact the privacy officer, the security officer, the compliance officer, my supervisor, or Human Resources without fear of retaliation.

_____	_____	_____
Print Student Name	Student Signature	Date
_____	_____	_____
Print Witness Name	Witness Signature	Date

*Your witness may be a parent, spouse, teacher, school counselor, or WMC staff member. If not a WMC staff member, please indicate their relationship and contact information here: (email and phone)

_____

Shadow Student Health Agreement

- As a student of Winneshiek Medical Center, I understand that it is my responsibility to follow all applicable health guidelines, protocols, and policies.
- I understand that I must notify WMC if I have a known exposure to COVID-19, a fever, or other COVID-19 symptoms. I understand my experience may be canceled or rescheduled.
- I understand and agree that I must complete a daily assessment of my symptoms and monitor my temperature prior to reporting to work to assure that I am able to work safely.
- I agree to follow my department notification process if I am unable to work for any reason. If I do not know this, I will ask the education department.
- I attest that by reporting to work for my scheduled shift:
    - I do not have any known exposures to COVID-19 without proper PPE
    - I have not had a fever (>100 °F) at any point during the last 72 hours
    - I do not have recent respiratory or other COVID-related symptoms
        - Aches, chills, fatigue
        - GI distress (nausea, diarrhea, vomiting)
        - Respiratory distress (coughing, shortness of breath)
        - Headache
        - Sore throat
        - Loss of taste / smell
        - Sinus congestion
    - If I develop symptoms while at my shadow experience, I will notify my supervisor.
    - I do not have any other symptoms that would prevent me from working.

Student / Volunteer Member Name [Please print]:_____

Signature: _____

Date: _____