Conemaugh Health System

Conemaugh Health System

Job Shadow Program Application

For More Information on Job Shadowing Please Contact:
Kathy Gorzelsky
Conemaugh Memorial Medical C enter
Human Resources
(814) 534-3177 or kgorzel@conemaugh.org

Conemaugh Health System

Job Shadow Application

Thank you for your interest in job shadowing through the Conemaugh Health System. We offer opportunities for high school students and adults to learn about a variety of health care careers in clinical and non-clinical settings or for college students to obtain experience for degree programs. To participate, you will need to review the contents of this packet carefully. The application also includes several sections that must be completed, signed, and returned.

What is Job Shadowing?

Job Shadowing is an observational experience that provides an opportunity for participants to see, firsthand, the healthcare workplace and the day-to-day work of professionals in the health care field. Hands-on patient care is not part of the Job Shadow experience and is not permitted.

Each shadowing match is based on a careful process. Conemaugh Health System will make every attempt to provide an experience in the area of interest. Availability and schedule limitations within our organization also play in determining placement opportunities. S*tudents will not be permitted in certain areas of the hospital and we will look at each request on a case by case basis.*

We will not match students to medical professionals who are not employed by CHS.

How Long Can I Shadow?

- High School students, age 16 and over, and adults who are interested in a career in the medical field are eligible to shadow for 4 hours.
- Students aged 18 and over who need shadowing hours to meet pre-acceptance requirements for a degree program are eligible to shadow for up to 5 days or 40 hours when the safeguards of this policy are followed.
- If you are already employed by CHS and would like to job shadow because you are considering a career change, you must job shadow on your own time. You may shadow up to one day or no more than 8 hours.

Why Consider a Health Care Profession?

- Healthcare careers are rewarding and fulfilling
- Many careers related to healthcare are in demand
- There are many, varied healthcare job opportunities

How Should I Prepare for the Experience?

Come prepared for the Job Shadow Experience as if you were coming for a Job Interview. You should have a baseline knowledge of the career. Develop your own questions, but here are some sample questions you might ask your preceptor:

- What kind of education & skills are needed for the job?
- Do you need a license? If yes, what does it take to get a license?
- How and why did you get started in this field?
- What do you like best and least about this job?
- Is continuing education required for this job?
- How many hours do you typically work?

How Long Does it Take to Process a Request?

It will take a minimum of ten (10) working days once you have sent us your completed Job Shadow Application/required documentation.

What Do I Need?

Applicants must submit the following to Conemaugh Memorial Medical Center Human Resources Department. The application will then be processed.

- ☐ Short CV or Bio
- ☐ Completed Job Shadowing Application
- ☐ Signed Job Shadowing Opportunity Conditions of Participation Form
- ☐ Completed HIPAA *(Health Insurance Portability & Accountability Act*) Fundamentals Agreement
- ☐ Signed Confidentiality & Security Agreement
- ☐ Signed Waiver of Liability & Hold Harmless Form
- ☐ Signed Dress & Appearance Policy Form
- ☐ If under 18, Consent for Treatment of Minor Child.
- ☐ Understanding of Policies initialed for: Rules of Conduct, Infection Control Guidelines, No Smoking Policy, Temporary ID Badge, Fire Plan and Emergency Codes

If the Job Shadow Experience is more than one day (8 hours) the following are required:

- ☐ PATCH (Pennsylvania Access to Criminal History)
- ☐ Department of Human Services Fingerprinting
- ☐ PA Child Abuse History Clearance
- ☐ Department of Aging ((PA resident less than 2 years)
- ☐ Urine Drug Screen (within 30 days)
- ☐ Letter of attestation from school or physician for required immunizations (including Flu Shot/2 Step TB Skin Test if >2 days shadow)

**PLEASE SEE LAST PAGE FOR MORE INFORMATION ON OBTAINING CLEARANCES

COVID-19 VACCINE: For a Shadow Experience

greater than 1 day/8 hours, you must provide proof of COVID vaccine (copy of card)

- ☐ Copy of COVID-19 Vaccine Card - or
- ☐ Completed & signed Medical Exemption Form - or
- ☐ Completed & signed Religious Exemption Form

You may drop off your completed application to Human Resources at the Main Campus G3, 3rd Floor or mail to:

Conemaugh Memorial Medical Center
1086 Franklin Street
Johnstown, PA 15905
ATTN: Human Resources/Kathy Gorzelsky

Parking

Parking is available in the North Garage on the Memorial Medical Center Campus. The cost is $3/day. *See link to campus map at www.conemaugh.org*

Name Badge

- College Students: Please wear your valid PHOTO school ID. (Must be worn on lanyard, etc.) If you do not have a photo ID, we will escort you to Security* for a badge. ***Please bring along an official/valid photo ID card and be prepared to present it to confirm your identity.***
- High School Students: You will be given a stick-on name badge for the day.

Report To

Depending on location, we will inform you of where you will meet your preceptor.

Students experiencing an acute infection such as respiratory illness, fever, stomach issues or conjunctivitis (pink eye) will need to reschedule their visit.

☐ I ACCEPT

By checking the "I ACCEPT" Button, you agree that any document you electronically sign is the legal equivalent of your handwritten signature, and you consent to the legally binding terms & conditions.

Conemaugh Health System Job Shadow Application

Please Print Legibly			Today's Date:
Name:			Date of Birth:
Address:	City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email Address:	
MINORS: Name of Parent/Guardian			Phone # of Parent or Guardian:
If Under 18 Require Parent or Guardian Signature:			
Emergency Contact & Relationship:			Phone # Emergency Contact:
☐ High School Student ☐ College Student	Name of School: Grade/Year:		

Hospital Requested:
☐ Memorial Medical Center ☐ Miners Medical Center ☐ Meyersdale Medical Center ☐ CPG (Physician Group)

Number of Requested Hours*: High School Students: ☐ 4 Hours ☐ Adult 4 – 8 Hours College Students: _____ (*Indicate Hours Requested)*	High School Students may request up to 4 Hours. College Students: 5 days or 40 hours. Adults for Career Change or Job Applicant 4 to 8 HRS

Reason for Shadow:
☐ Interest in Healthcare Career Required for College Application Process (PA, NP, PT/ST/OT)
☐ Required for High School Credit

Your Availability:
☐ MONDAY ☐ TUESDAY ☐ WEDNESDAY ☐ THURSDAY ☐ FRIDAY
☐AM only ☐ All Day
☐PM only Potential Dates:

FIELD OF INTEREST:

If you have any disability requirements, please contact Kathy Gorzelsky @ 814-534-3177 in advance of placement.

Job Shadowing Opportunity Conditions of Participation

The Conemaugh Health System is committed to protecting our patients' rights to privacy and confidentiality. Students and potential future employees are invited to spend time in the healthcare field where further exposure to the healthcare environment is requested. We are providing this opportunity so that you may observe and experience our culture and environment.

I, *(Please print)* _____ desire to gain exposure in the field of healthcare by observing the practice of healthcare workers through the Conemaugh Health System.

I understand that the Conemaugh Health System (known as CHS) is willing to avail its premises to me for the sole purpose of observing or "shadowing" its healthcare workers provided I agree and adhere to the conditions set forth below:

1. CHS shall retain ultimate responsibility for all patient care activities. I shall not, at any time, touch or be directly involved in provision of patient care.
2. CHS reserves the right, at any time, to discontinue this shadowing opportunity and to prohibit me from its facility, for any reason, or no reason, whatsoever.
3. CHS makes no representation or warranty concerning the quality of this shadowing opportunity, nor does it make any representation or warranty concerning whether it will suitably prepare me for future practice in any capacity or position.
4. For those doing a Job Shadow Experience more than 8 hours or one day:

   Prior to my job shadow start, I shall submit to CHS a letter of attestation from my school or physician verifying the following health information relative to myself:

   a. Verification of Health
   b. Negative 2-step Tuberculin Skin Test in the past 12 months *(If job shadow experience is more than 2 days)*
   c. Immunizations are up to date *(Rubella, Rubeola, Varicella, Mumps, Tetanus, and Hepatitis B)*
   d. Current flu shot if shadowing experience is between October 1 through March 31
   e. Proof of COVID-19 Vaccine or proof of exemption.

   CHS will adhere strictly to the above-listed health requirements and documentation thereof. Therefore, I understand that I will not be permitted to begin the shadowing experience without fulfilling the same.

5. CHS will adhere strictly to the practice of universal/Standard Precautions as outlined in the facility's policy of the same name, to avoid any contact with blood, body fluids or potential infectious materials.

   In the event of an exposure, it will be my responsibility to:

   a. Report the exposure to my preceptor and/or appropriate facility personnel
   b. Report to a designated physician at the facility, the site-specific Emergency Department or to my own physician as soon as possible after exposure, but in no event later than the day following the exposure. This is mandatory to confirm a significant exposure and to initiate any immediate therapy.

Job Shadowing Opportunity Conditions of Participation (Continued):

c. If there is significant exposure, I will have my physician conduct baseline testing and request that the facility obtain testing of the source patient's blood. I will communicate my request to the appropriate facility personnel.
d. All emergency first aid rendered in case of an accident or sudden illness and/or all exposures will be treated at my expense. Any required follow-up treatment, testing or counseling will be conducted by my personal physician and not by CHS.

6. I agree to ensure that all information, whether patient, proprietary or business-related, encountered at the facility remains strictly confidential.

As a Job Shadow guest of Conemaugh Health System, I agree to respect the privacy and confidentiality of all patients, families and staff of Conemaugh Health System and its Affiliates.

I have read and agree to follow the Conditions of Participation state above during my shadowing time at Conemaugh Health System.

Signature below indicates understanding and acceptance of the Conditions of Participation.

Agreed to this date: _____

_____ _____

Name (Please Print) Signature of Participant

_____ _____

Parent or Guardian Name *(Required if Under 18 years of age)* Signature of Parent/Guardian

_____ _____

School and/or Program (If Applicable) Signature of Authorized School Official

HIPAA Fundamentals Training

Introduction

What is HIPAA?

- HIPPA stands for Health Insurance Portability & Accountability Act. HIPAA is a federal law that protects "Protected Health Information (PHI)
- The law allows for penalties such as fines and/or prison for people caught violating patient privacy.
- Patient information includes things such as:
    - The patient's name and other general information about the patient.
    - The patient's diagnosis and other medical conditions that the patient may have
    - Treatments, tests, and medications that the patient receives
    - Information in the patient's medical record/computer system or information that may be posted in the patient's room.
- Conemaugh Health System is legally required by law to protect the privacy and security of health care information of all patients treated in any of our facilities.

As a Job Shadow Participant, I agree that I will not:

- Read the diagnosis, treatment, test results, financial or other information on a patient's chart.
- Disclose any privileged information to anyone or any entity
- Access, review or receive copies of any medical information about anybody including myself or family members/friends.
- Download any protected health information on removable storage media for any purpose.
- Document any protected health information on forms or reports that need turned in to my school.
- Discuss protected health information with other students or employees
- Dispose of any documents with protected health information.
- Discuss patient and protected health information in public areas such as elevators, cafeteria, and hallways.

My signature below acknowledges that I have read The HIPAA Fundamentals Training and agree to abide by the terms. I understand that any violation on my part of the above conditions could result in immediate termination of my Job Shadow Experience.

Name: _____ Date: _____

Signature: _____

Waiver of Liability and Hold Harmless Agreement

In consideration for receiving permission to participate in Conemaugh Health System's (hereafter referred to as CHS) Job Shadow Program or other HealthCare Observation Program (Thereafter referred to as the **Program**), I hereby release, waive, discharge and covenant not to sue CHS, its officers, servants, agents and employees (Hereinafter referred to as "**Released Parties**") from any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or relating to any loss, damage or injury, including death, that may be sustained by me, or to any property belonging to me, whether caused by the negligence of the Released Parties or otherwise, while participating in the Program or while in, or upon the premises where the Program is being conducted, while in transit to or from the premises or in any place or places connected with the program.

1. I am fully aware of risks and hazards connected with being on the premises and participating in the Program, and I hereby elect to voluntarily participate in the Program, to enter upon the above-named premises and engage in activities knowing that conditions may be hazardous or may become hazardous or dangerous to me and my property. I voluntarily assume full responsibility for any risk of loss, property damage or personal injury, including death, that may be sustained by me or any loss or damage to property owned by me, as a result of my being a participant in the Program, whether caused by the negligence of Released Parties or otherwise.
2. I further hereby agree to indemnify and save and hold harmless the Released Parties and each of them, from any loss, liability, damage or costs they may incur due to my participation in the Program, whether causes by the negligence of any or all of the releasees or otherwise.
3. It is my express intent that this Release shall bind the members of my family and spouse, if I am alive, and my heirs, assigns and personal representative, if I am deceased, and shall be deemed as a Release, Waiver, Discharge and Covenant Not to Sue the above-named Released Parties.

In signing this release, I acknowledge and represent that:

A. I have read the foregoing release, understand it, and sign it voluntarily as my own free act and deed
B. No oral representation, statements, or inducements, apart from the foregoing written agreement, have been made.
C. I, my parents, or guardian is at least eighteen (18) years of age and fully competent
D. I execute this Release for full, adequate, and complete consideration fully intending to be bound by same.

Participants Signature: _____Date: _____

Name Printed: _____

If Participant is under 18 years of age:

Parent or Guardian Signature: _____

Parent or Guardian Name Printed: _____

Job Shadow Program – Dress & Appearance Policy

While participating in the Job Shadowing Program we require you to observe specific standards regarding your personal appearance.

- You should dress in a professional manner.
- Clothing must be clean and fit properly. Women, no crop tops. Upper and lower torso must be covered. Cleavage should not be visible.
- Khaki's, Dockers, dress pants, skirts/dresses no shorter than 2 inches about the knee are acceptable. Pant hemlines may sit at or below the ankle. No denim jeans permitted.
- Polo shirts, dress shirts, blouses are acceptable. No logo item shirts or shirts with sayings or sports teams are permitted. No spaghetti strap tops, or bare shoulders are permitted.
- Socks or hose must be worn with closed toe shoes. Tennis shoes or soft soled shoes are permitted. No sandals or flip-flops.
- Only earrings are permitted. Any other piercings must be removed or covered up.
- Tattoos are permitted in moderation and good taste. Any tattoos that are offensive, vulgar, indecent, hate charged, gang affiliated, related to death, sexist, racist etc. must be covered up.
- Perfume and colognes should not be worn as some patients may be allergic.
- Please always wear your school ID badge or hospital issued ID Badge when you are job shadowing.
- Keep all cell phones turned off and put away while you are in your shadow experience.
- If your Job Shadow Experience requires you to wear scrubs, they will be provided.

I have read and understand the Dress & Appearance Policy for the Job Shadow Program

Print Name: _____

Signature: _____

Date: _____

Rules of Conduct

While participating in the Job Shadowing Program you must adhere to the policies regarding disruptive behavior.

I understand that "disruptive behavior" refers to any intimidating and/or disruptive behavior including but not limited to: verbal outbursts, name-calling, use of language that is profane, vulgar, sexually suggestive or sexually explicit, degrading, or racially/ethically/religiously slurring, degrading jokes or comments, physical threats, any unwanted touching, obscene gestures, physical throwing of objects, assault and other acts or behaviors deemed to be intimidating or harassing, including passive activities such as deliberate failure to follow organizational policies. Job Shadow Participants should not be on their cell phones except for urgent matters. I agree to abstain from these behaviors and understand that I may be asked to leave and/or that my shadow experience will be terminated for failure to abide by the Standards of Conduct Policy.

Job Shadow Participant Initials: _____

Infection Control Guidelines

1. Handwashing is the best way to prevent the spread of infection. Wash your hands before and after leaving a patient area, before and after meals and after using the restroom. Wash your hands for at least 20 seconds at a time.
2. As a Job Shadow Participant, you are not permitted to transport test tubes, containers, specimens, etc.
3. As a Job Shadow Participant, you are not permitted to touch a patient or be directly involved in the provision of patient care.

Job Shadow Participant Initials: _____

Shadow Experience

I understand that during the shadow experience I am there to shadow/observe only. I understand I am not to touch a patient, provide hands on care or perform any type of work.

Job Shadow Participant Initials: _____

Smoking Policy

As a health care system committed to the safety and health of the community, CHS is very conscious of the adverse effects of smoking. Therefore, CHS enforces a "No Smoking Policy" on hospital property or any time during your Job Shadow Experience.

Job Shadow Participant Initials: _____

Temporary ID Badge

As a participant in the Job Shadow Program, you must wear proper identification. College students, please wear your school ID if it has your picture. If not, report to Security on 2nd Floor Clinical Pavilion for your temporary badge. The badge is only valid during your time as a Job Shadow Participant. Wear the badge above the waist, clearly visible. High School students or one day adults will be given a temporary badge the day they shadow.

Job Shadow Participant Initials: _____

Fire Plan

The word RACE is just a memory helper for the Fire Plan. You must know the four Action Steps of the plan:

1. Remove (rescue) everyone from immediate danger and close the door.
2. Alarm - Pull the nearest fire alarm pull station and dial your facility emergency assistance number (222)
3. Close all doors in the alarm area to contain the head and smoke.
4. Extinguish the fire, but only if it is small and contained.

Job Shadow Participant Initials: _____

Fire Extinguisher Operation

Remember P.A.S.S.

Set the fire extinguisher down, grasp the neck of the extinguisher with one hand and then:

P – Pull the pin located at the handle
A – Aim the hose or nozzle at the base or edge of the fire.
S – Squeeze the handle down while holding the extinguisher upright.
S – Sweep the hose or nozzle from side to side.
NOTES:

- Discharge the extinguisher until it runs empty
- Discharge time – they all last about one (1) minute
- Remember they are only for small, contained fires.

Job Shadow Participant Initials: _____

Security/Access

As a Job Shadow Participant, I understand that I will be paired with a preceptor and will be with the preceptor at all times during my shadow experience. I will not be asked to function independently or be sent anywhere in the hospital unaccompanied by staff. Discretion in allowing observation in certain patient situations will be assessed at the time of the experience. Once the shadow experience is completed, I must return my badge.

Job Shadow Participant Signature: _____

CONEMAUGH HEALTH SYSTEM - MEMORIAL MEDICAL CENTER

Conemaugh Health System
Duke LifePoint Healthcare

Plain Language Codes

CODE ACTIVATION

EVENT TYPE	CODE NAME	MAIN CAMPUS - INPATIENT BUILDINGS (E and M Bldgs., P Bldg. (Ashman/Rose), Clinical Pavilion, Good Samaritan)	MAIN CAMPUS - NON-INPATIENT BUILDINGS (F and G Bldgs., 130 W. Osborne, 1017 Franklin St. (MIS), 1111 MOB, Wessel)	LEE CAMPUS	OUTLYING AREAS
CARDIAC ARREST - ADULT	MEDICAL EMERGENCY + LOCATION	222	Dial 4 (outside line) then 911	Dial 4 (outside line) then 911	Dial outside line* then 911
CARDIAC ARREST - PEDIATRIC	MEDICAL EMERGENCY PEDIATRIC + LOCATION	222	Dial 4 (outside line) then 911	Dial 4 (outside line) then 911	Dial outside line* then 911
DETERIORATION OF ANY INDIVIDUAL	RAPID RESPONSE + LOCATION	222	Dial 4 (outside line) then 911	Dial 4 (outside line) then 911	Dial outside line* then 911
STROKE SYMPTOMS	STROKE ALERT + LOCATION	222	Dial 4 (outside line) then 911	Dial 4 (outside line) then 911	Dial outside line* then 911
TRAUMA OF ANY INDIVIDUAL	TRAUMA ALERT + ETA	222	Dial 4 (outside line) then 911	Dial 4 (outside line) then 911	Dial outside line* then 911
CARDIAC SYMPTOMS/STEMI	STEMI ALERT + LOCATION + ETA	222	Dial 4 (outside line) then 911	Dial 4 (outside line) then 911	Dial outside line* then 911
EVACUATION	EVACUATION + LOCATION	222	222	222	Dial outside line* then 911
BOMB THREAT	BOMB THREAT + LOCATION	222	222	222	Dial outside line* then 911
FIRE	FIRE ALERT + LOCATION	Pull Alarm 222	Pull Alarm 222	Pull Alarm 222	Pull Alarm / Dial outside line* then 911
ABDUCTION OR ELOPEMENT	MISSING PERSON + DESCRIPTOR (MALE OR FEMALE + AGE) + LOCATION	222	222	222	Dial outside line* then 911
ACTIVE INTRUDER OR PERSON WITH A WEAPON	ACTIVE INTRUDER + LOCATION	222	222	222	Dial outside line* then 911
COMBATIVE PATIENT OR PERSON	SECURITY ALERT + LOCATION	222	222	222	Dial outside line* then 911
DISASTER WITH PATIENT SURGE	DISASTER ALERT TRAUMA	222	222	222	Dial outside line* then 911
CHEMICAL OR BIOLOGICAL DISASTER	DISASTER ALERT CHEMICAL/BIOLOGICAL	222	222	222	Dial outside line* then 911
UTILITY FAILURE	UTILITY FAILURE (TYPE) + LOCATION	222	222	222	Dial outside line* then 911
WEATHER EMERGENCY	WEATHER ALERT + DESCRIPTOR (TYPE OF WEATHER)	222	222	222	Dial outside line* then 911
HAZARDOUS MATERIAL SPILL	HAZ MAT SPILL + LOCATION	222	222	222	Dial outside line* then 911

* IF NECESSARY

OUTLYING AREAS - Explain Emergency Type when calling 911

. . . . IN CASE OF FIRE . . . .

R	RESCUE	Rescue person(s) if in immediate life-threatening danger.
A	ALARM	Pull nearest fire alarm, dial 222, tell operator your location and the nature of the emergency.
C	CONTAIN	Close all doors and windows.
E	EXTINGUISH	Extinguish or Evacuate.

P	PULL	the locking pin or release the lever.
A	AIM	the extinguisher by holding the nozzle firmly. Hold the extinguisher upright.
S	SQUEEZE	the handle.
S	SWEEP	the nozzle back and forth slowly, aiming at the base of the flames.

Consent for Medical Treatment for Minor Child

For Job Shadow Participants under the age of 18, I/WE hereby authorize employees or agents supervising our said minor child to act on our behalf in authorizing and consenting to emergency medical care for said minor if he/she becomes ill or is injured while participating in the Job Shadow Program.

This Authorization and Consent may be presented to the appropriate emergency medical staff at such time as emergency medical care is required.

I/WE hereby RELEASE and discharge the Conemaugh Health System from any and all claims of any nature whatsoever, which may arise out of the decision to provide emergency medical care.

Participants Name: _____

_____ Date: _____

Signature of Parent or Legal Guardian

_____ Date: _____

Signature of Parent or Legal Guardian

Conemaugh Health System

COVID GUIDELINES & AGREEMENT
Job Shadow Participants at Conemaugh Memorial Medical Center

COVID -19 Pandemic Restrictions have been lifted. We ask you to be flexible should anything change during your shadow experience.

1) Job Shadow Participants are not permitted in COVID-19 patient rooms in the Emergency Room or on the floors.

2) Job Shadow Participants may be asked to wear a mask in certain areas or if a patient requests that you wear a mask. You can bring a hospital grade mask or if you do not have one, one can be provided if needed.

3) Job Shadow Participants will keep hands clean by washing hands with soap and water or using a hand sanitizer that contains at least 60% alcohol.

4) Job Shadow Participants who have a temperature or who are symptomatic should stay home and call Kathy Gorzelsky at (814) 534-3177.

5) As safety precautions and guidance may change, the Job Shadow Participant agrees to abide by said changes.

6) The participant and/or participant's guardian (if under 18) has made the determination that it is safe for the Job Shadow participant to job shadow in the Conemaugh Health System.

7) The Job Shadow Participant agrees to abide by all the Conemaugh Health System's safety precautions and guidance.

8) I acknowledge and agree that Conemaugh Health System is not responsible for my potential exposure to COVID-19 or my contraction of COVID-19, while serving as a Job Shadow participant.

_____

Print Job Shadow Participant Name

_____ _____

Job Shadow Participant Signature Date

_____ _____

Parent /Guardian's Signature (Student under 18) Date

Conemaugh Health Systems

Confidentiality and Security Agreement

I understand that the facility or business entity named below (the "Company") in which or for whom I work, volunteer or provide services, or with whom the entity (*e.g.*, physician practice) for which I work has a relationship (contractual or otherwise) involving the exchange of health information (the "Company"), has a legal and ethical responsibility to safeguard the privacy of all patients and to protect the confidentiality of their patients' health information. Additionally, the Company must assure the confidentiality of its human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information (collectively, with individually identifiable health information and protected health information, "Confidential Information").

In the course of my employment / assignment at the Company, I understand that I may come into the possession of this type of Confidential Information. I will not use company systems to access patient information if it is not necessary to perform my job related duties. This includes NOT accessing my own health information or that of my child or person's for which I am personal representative via the company systems. The Company's Privacy and Security Policies are available through the Company, copies of which will be provided upon request. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to Confidential Information.

1. I will not disclose or discuss any Confidential Information with others, including friends or family, who do not have a need to know it.
2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any Confidential Information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation, even if the patient's name is not used. I will make every reasonable attempt to refrain from practices that might lend itself to unintended breach of patient confidentiality.
4. I will not make any unauthorized transmissions, inquiries, modifications, or deletions of Confidential Information.
5. I agree that my obligations under this Agreement will continue after termination of my employment, expiration of my contract, or my relationship ceases with the Company.
6. Upon termination, I will immediately return any documents or media containing Confidential Information to the Company.
7. I understand that I have no right to any ownership interest in any information accessed or created by me during my relationship with the Company.
8. I will act in the best interest of the Company and in accordance with its Company's Privacy and Security Policies at all times during my relationship with the Company.
9. I understand that violation of this Agreement may result in disciplinary action, up to and including termination of Company employment, suspension and loss of privileges, and/or termination of authorization to work within the Company, in accordance with the Company's policies.
10. I will only access or use systems or devices I am officially authorized to access, and will not demonstrate the operation or function of systems or devices to unauthorized individuals.
11. I understand that I should have no expectation of privacy when using Company information systems. The Company may log, access, review, and otherwise utilize information stored on or passing through its systems, including e-mail, in order to manage systems and enforce security.
12. I will practice good workstation security measures such as locking up electronic media devices when not in use, using screen savers with activated passwords appropriately, and position screens away from public view.
13. I will practice secure electronic communications by transmitting Confidential Information only to authorized entities, in accordance with approved security standards.
14. I will:
    a. Use only my officially assigned User-ID and password (and/or token (e.g., Multi-Factor Authentication "MFA").
    b. Use only approved licensed software.
    c. Use a device with virus protection software.
15. I will never:
    d. Share/disclose user-IDs, passwords or MFA.
    e. Use tools or techniques to break/exploit security measures.
    f. Connect to unauthorized networks through the systems or devices.
16. I will notify my manager, Facility Information Security Officer, or appropriate Information Services person if my password has been seen, disclosed, or otherwise compromised, and will report activity that violates this agreement, privacy and security policies, or any other incident that could have any adverse impact on Confidential Information.
17. I will only access software systems to review patient records or Company information when I have a business need to know, as well as any necessary consent. By accessing a patient's record or Company information, I am affirmatively representing to the Company at the time of each access that I have the requisite business need to know and appropriate consent, and the Company may rely on that representation in granting such access to me.
18. I will accept full responsibility for the actions of my employees who may access the Company software systems and Confidential Information and will ensure that any such employee will execute their own Confidentiality and Security Agreement.
19. I understand that the Company may, at its sole reasonable discretion, rescind any person's access to any information system at any time. I further understand that if I am a member of the medical staff, any violation of the terms contemplated herein or of the facility's rules and regulations, may subject me to disciplinary action pursuant to the facility's medical staff bylaws .

Signing this document, I acknowledge that I have read this Agreement and I agree to comply with all the terms and conditions stated above.

Emp# / UnivID#	**Signature**			**Printed Name**	**Date**
☐	☐	☐	☐	☐ OTHER **Business/School Entity Name, DOB & Job Title ALL MUST be included**	
Cone Memorial MC	Cone Meyersdale MC	Cone Miners MC	Cone Physician Practice	**Date of Birth**:	**JOB TITLE**:

January 8, 2020

1. Pennsylvania Child Abuse History Clearances

https://www.compass.state.pa.us/CWIS

You'll be asked to create an Account with Username & Password

They will ask you for "Purpose of Certification". Check "Volunteer" and where it says "Other" indicate Shadow Program.

Approximately 10 days after you submit your request, you can log back in and print off your clearance.

2. Department of Human Services Fingerprinting

Register online: https://uenroll.identogo.com/
Service Code: 1KG756

3. FBI Fingerprinting

If you have not been a resident of Pennsylvania for two years (2) you will need additionally do FBI fingerprinting.

Register online: https://uenroll.identogo.com//

Service Code: 1KG8RJ

Facility Code: 5129

4. Drug Urine Screen

10-Panel Drug Screen from a federally approved site. Please remember that Drug Screen cannot be older than 30 days so plan accordingly when obtaining the other clearances so that your screen doesn't expire before your other clearances are completed.

You also can schedule it through Corporate Care in East Hills (814) 266-8466. They take walk-in up until 3:00 p.m. (Monday – Friday).

Or you can schedule an appointment with Ebensburg Corporate Care at 814-471-0256.

Cost is $55