Hunterdon Health

STATEMENT OF UNDERSTANDING AND COMPLIANCE WITH HUNTERDON HEALTH'S CODE OF ETHICS
Shadow Acknowledgement

Name: ____

Department: ____

Shadow Date: _______________________________________

As a participant in the shadowing program at Hunterdon Health, I certify that I have been educated on the Corporate Compliance Program, and agree to abide by it during the entire term of my shadowing experience. I acknowledge that I have a duty to report any alleged or suspected violation of the Code of Ethics, or the Corporate Compliance Program.

______________________________ ______________________________
Date Signature

____
Print Name

Hunterdon Health

CONFIDENTIALITY AND HIPAA PRIVACY ACKNOWLEDGMENT FORM FOR SHADOWS

Information about Hunterdon Health, its employees, and its patients should be released only on a "need to know" basis, when related to a business need, patient care need, or internal/external reporting. Individuals participating in a shadowing experience at Hunterdon Health will have a legal and ethical responsibility to protect the confidentiality of information related to Hunterdon Health, its employees, and its patients. In the course of your interactions at Hunterdon Health, you may be given information from a variety of sources including staff, and/or patients. You are prohibited from discussing or sharing information with anyone who has no need to know the information. Discussing or electronically sharing confidential information with neighbors, friends, or relatives is prohibited. When discussing positive aspects of your shadowing experience, please keep confidentiality in mind at all times and do not share names or other confidential information. No pictures of patients should be provided or taken by the media.

In certain circumstances, you may be made aware of PHI (Protected Health Information). Understand that federal and state law, including the Health Insurance Portability and Accountability Act ("HIPAA"), protects the privacy and confidentiality of "protected health information" ("PHI"). PHI is defined as any information that identifies an individual and that relates to the past, present or future physical or mental health or condition of an individual or the provision of health care to an individual. PHI includes even the basic fact that an individual is a resident of a community or a client of a program. I agree to keep all confidential information, including PHI specific to Hunterdon Health's patients and employees in strict confidence. I understand that failure to do so will result in termination of my participation in the job shadowing experience and may expose me to potential legal liability.

By signing this form, you agree: 1) to adhere to Hunterdon Health's confidentiality and privacy as a condition of receiving access to Hunterdon Health's information; 2) that your obligations under this Agreement will continue after your relationship ceases with Hunterdon Health.

Confidentiality:

1. I will not access, disclose or discuss any Confidential Information with others, including friends or family, who do not have a legitimate business need to know. I will not use my access to demonstrate Hunterdon Health's computer systems and/ or to reveal confidential information to unauthorized individuals.
2. I will not in any way access, divulge, copy, release, sell, loan, alter, or destroy any Confidential Information for curiosity or personal gain.
3. I will not discuss Confidential Information where others can overhear the conversation. It is not acceptable to discuss Confidential Information even if the patient's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modifications, or purging's of Confidential Information.
5. I understand that I have no right to any ownership interest in any information accessed or created by me during and in the scope of my relationship with Hunterdon Health.

Name (PRINT):	Name (SIGNATURE) :	DATE:

LIABILITY WAIVER FOR SHADOWS

I understand and acknowledge that by participating in the shadowing program at this time, I may be exposed to certain dangers and risks, including but not limited to all risks associated with contracting an infectious disease, including COVID-19. I understand and acknowledge that care of a patient with an infectious disease may occur as part of my shadowing experience.

I further acknowledge that Hunterdon Health has put in place preventative measures to reduce the spread of any/all infectious diseases, including COVID-19 and it is the expectation that I will follow all protocols and policies.

I further acknowledge that Hunterdon Health cannot guarantee that I will not become exposed or infected with an infectious disease, including COVID-19.

I further acknowledge that I am solely responsible for my choice to engage in an on-site job shadowing experience and that I have voluntarily chosen to participate. I understand that I assume all dangers and risks inherent with participating.

I further acknowledge that my participation in the program does not constitute employment for any duration and that I will not be performing compensable work while participating in the program.

I acknowledge the risk and absolve Hunterdon Health of liability during any clinical rotation at any Hunterdon Health facility.

<u>I attest that:</u>

* I am not experiencing any symptom of illness such as cough, shortness of breath or difficulty breathing, fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, nausea, vomiting, diarrhea, fatigue, nasal congestion or runny nose, or new loss of taste or smell.

* To the best of my knowledge, I have not been exposed to someone with a suspected and/or confirmed case of COVID-19.

* I have not been diagnosed with COVID-19 in the last 10 days (or in the last 20 days if I have a compromised immune system).

I hereby release and agree to hold Hunterdon Health harmless from, and waive on behalf of myself, my heirs, and any personal representatives any and all causes of action, claims, demands, damages, costs, expenses and compensation for damage or loss to myself and/or property that may be caused by any act, or failure to act of Hunterdon Health.

I understand that this release discharges Hunterdon Health from any liability or claim that I, my heirs, or any personal representatives may have with respect to any bodily injury, illness, death, medical treatment, or property damage that may arise from, or in connection to, my job shadowing experience at Hunterdon Health.

________________________________ _______________

Signature: Date:

SHADOWING ACKNOWLEDGEMENT AND CONSENT

In consideration of the opportunity to participate in a job shadow opportunity at Hunterdon Health, I agree as follows:

1. I hereby release, waive and discharge Hunterdon Health and its respective affiliate companies, parents, officers, directors, agents, contractors, subcontractors and employees from all liability to me and to my conservators, guardians or other legal representatives, assigns, and heirs for any and all claims, demands, losses or damages on account of any injury, death, or damaged property, arising out of my participation in the job shadowing program.

2. I hereby release, waive and discharge Hunterdon Health from all liability to me and my conservators, guardians or other legal representatives, assigns, and heirs for any and all claims, demands, losses or damages on account of any injury, death, or damaged property, arising out of any negligence relating in any way to my job shadowing experience at Hunterdon Health, including, without limitation, Hunterdon Health's construction, use, maintenance and operation.

3. By signing this Agreement I consent to the use of my name and/or photograph or other likeness by Hunterdon Health without any additional compensation or inspection. I also confirm that I am over the age of 18 or if I am under the age of 18, my parent or legal guardian has signed on my behalf, and that all facts in this Agreement are true. I have read this Agreement and Release and Waiver of Liability and understand that by signing it I have given up substantial rights. I sign this Agreement voluntarily.

____

Name of Participant (please print):

____

Signature of Participant or Parent/Legal Guardian, if applicable

____

Date

____

Date of Birth

____

Printed Name of Parent/Legal Guardian, if applicable