Shadow Student Orientation Acknowledgement

Student first and last name: _____

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

Initial	Role of the Student at WinnMed
Initial	Mission, Vision and Values
Initial	Name Badge
Initial	Tobacco Free Campus
Initial	Parking
Initial	Timeliness / Attendance
Initial	Conduct and Behavior
Initial	Alcohol and Drugs
Initial	Phones and Mobile Devices
Initial	Appearance Expectations
Initial	Customer Service / Courtesy
Initial	Communication
Initial	Diversity and Inclusion and Language Services
Initial	General Safety, including Preventing Falls, Abuse Reporting, and Event 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	Immunizations 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 WinnMed.

****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

STUDENT INFORMATION SHEET – SHADOW STUDENT

Print first/middle/last name: _____ Today's Date: _____

JOB ROLES /Departments REQUESTED: _____

Date of Birth (required): _____

DATES / DAYS OF WEEK / TIMES "NOT" AVAILABLE: _____

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

Address: _____City: _____ State: _____ Zip:_____

Emergency Contact: _____ Relationship:_____ Phone#_____
(Someone who can make medical decisions for you – parent, spouse, guardian.)
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.*

Annual Flu vaccine required for shadow students during the influenza season from October 1 – March 31. Covid vaccine recommended. If not Covid vaccinated, include exemption request letter.

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 WinnMed, 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 WinnMed Notes:

_____ Ticket to Ride sent to student

CONFIDENTIALITY AGREEMENT

All WinnMed 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 WinnMed 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 department to safeguard confidential information including computer access, workstations and discussion. I will log off or lock 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 WinnMed 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 WinnMed 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 WinnMed staff member. If not a WinnMed staff member, please indicate their relationship and contact information here: (email and phone)

_____

Submit

RETURN COMPLETED FORMS TO shadow@winmedical.org Rev 07/12/2023