TOUR/CLINICAL OBSERVER DATA SHEET

PLEASE CHECK ONE : ☐ TOUR ☐ OBSERVER

NAME: (Please Print) _____ SEX: ☐ M ☐ F

ADDRESS _____ PHONE _____

CITY _____ STATE _____ ZIP _____

SCHOOL _____

PROGRAM _____

CONTACT PERSON _____ PHONE _____

HCMC PRECEPTOR _____ PHONE _____

HCMC SPONSORING DEPT _____ VISIT DATES _____

GOALS/OBJECTIVES (Please be specific) _____

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1. I am requesting the opportunity to be an "observer" in the Hennepin County Medical Center's Observation Program. I understand I will be provided with the opportunity to experience a clinician's interaction with his/her patients.

2. I understand I will be observing many patient/physician encounters, all of them involving personal and sensitive medical information. I understand that it is absolutely necessary that I observe patient confidentiality and respect it at all times. I will not discuss any information with other students or staff, even anonymously in public places, including elevators, cafeterias or where members of the public may be present. If at any time during my experience I become aware that I personally know a particular patient, I will inform my preceptor and excuse myself from observing any examination or discussion. My preceptor will be responsible for my orientation and educational experience at HCMC. Any questions about the scope of my role should be directed to the preceptor immediately.

3. I understand that all contact with patients must be supervised at all times, and if I am inadvertently left unattended with a patient, I will immediately seek a staff person to assume responsibility for the patient.

4. I understand that being on hospital premises may pose a small but real risk of injury or illness. I agree to be responsible for any injury or illness that might occur as a result of my participation. I understand I am not an employee of HCMC and will receive none of the benefits of employment, including Worker's Compensation or defense and indemnification by Hennepin County for any claim brought against me.[1] The Employee Occupational Health & Wellness service is not available to me.

5. I understand I am responsible for any personal property I may bring with me, and that HCMC will not be responsible for any loss or theft.

6. I understand that HCMC requires that I be vaccinated or be immune to measles, mumps and rubella prior to this experience.

7. I am not aware that I have active TB, chicken pox or recent exposure to chicken pox or rubella. I have received information regarding infection control, safety and confidentiality and have thoroughly reviewed and am responsible for the contents of that information and will follow all hospital policies and procedures of HCMC.

8. I understand that if I am under the age of 18, a parent or guardian must sign this request before I begin this experience.

____ ________________

Observer Signature Date

____ ________________

Parent/Guardian Signature (if observer is under 18 years of age) Date

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☐ Observer has completed a background study form for HCMC. **- OR -** ☐ Observer will <u>not</u> be left unattended with a patient.

____ ________________

HCMC Preceptor Signature Date

<u>This form must be completed & signed by every observer before beginning their visit.</u>

Return this form to the HCMC preceptor who will forward it to the Office of the Medical Director, #O1.

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[1] I understand that even if I am participating in this program through a school program, that school does not assume responsibility for any of the activities undertaken as part of this visit. However, if I am participating through the program of a school or academic institution that has a formal affiliation agreement with HCMC, I understand that the terms and conditions of that affiliation agreement may supersede some of the conditions of my participation, such as defense and indemnification.

If you have any questions as to whether you are participating as part of an affiliated program, please contact your academic institution.

Hennepin County Medical Center
HCMC
Level 1 Trauma Center

701 Park Avenue
Minneapolis, MN 55415-1829
612-347-2121

CONFIDENTIALITY AGREEMENT

Hennepin County Medical Center is committed to honoring the privacy of all patients and employees and protecting all data and information as required by all applicable rules, regulations, and laws for sharing and handling such data.

The Minnesota Government Data Practices Act establishes categories and definitions for types of governmental kept data. Release of certain types of data is restricted by this statute. In general, an employee or agent of Hennepin County should not read or otherwise have knowledge of specific information about a patient or employee which is not required for the employee or agent to perform his or her duties. Any data which the employee or agent is aware of should not be shared unless required by another employee in the performance of his/her duties. Employees or agents of Hennepin County are responsible for complying with the various rules, regulations, and laws governing the collection, creation, storage, maintenance, dissemination, and access to data.

Patient information in a medical record and/or hospital computer system or other document created by a patient visit or otherwise gathered and known by hospital staff is private. Information on patients may not be released without specific written permission from the patient or the patient's authorized representative.

An employee or agent of Hennepin County must also obey all rules and regulations regarding the usage and disbursement of computer software that is purchased, licensed, leased, or in some other way bound by contract.

During the course of my employee or other relationship to Hennepin County, I will:

1. Only access information and data necessary to do my legitimate work activities.

2. Not discuss or share patient or employee information with another individual unless it is necessary for that individual to perform their work activities and they are authorized to have access to the information.

3. Exercise discretion in conducting conversations or acting in a manner which would reveal confidential information while in a public or semi-public areas such as elevators, cafeterias, etc.

4. Prevent unauthorized persons from accessing and viewing patient or employee data by not leaving patient information on computer screens, printers, or fax machines unattended in public or semi-public areas.

5. Inform my supervisor if I have reason to believe that anyone may have learned or has used my security code for accessing computer systems at Hennepin County.

6. Inform my supervisor if I observe untrained and unauthorized persons harming or accessing any Hennepin County computer systems through inappropriate use.

7. Use all property, data, and products including computer software in accordance with the applicable licensing agreements, lease agreements and contracts.

8. Acknowledge that I will be disciplined in a manner consistent with the Hennepin County Personnel Policy and Minnesota Government Data Practices Act if I am found to have violated any of the above provisions.

If I have questions regarding confidentiality of information, I will direct them to my supervisor or Information Security during regular business hours.

I agree to review this agreement annually and resign this agreement including any changes that may be requested by Hennepin County.

Employee or Agent Name (Print)	Employee or Agent Signature
Employee Number	Date
Employee Supervisor