Intermountain Health

Revised: 4/2024

Observational Experience (Job Shadow)

Please complete the following forms and return to your assigned Student Programs Coordinator.

A. Student Profile
B. Pre-requisite Testing Attestation
C. Access and Confidentiality Agreement
D. Confidentiality Guideline
E. Medical Incident & Disease Exposure Release of Liability
F. Required Immunizations

Student Profile / Identification

Incomplete packets will be returned

Please Print

Date:_________________________________ *(of packet completion and return)*

Legal name:____________________________ ___________ ______________________________
First *Middle Initial* *Last*

Preferred first name *(if different from legal name)*:____________________________

Previous last name *(if any)*:____ **Suffix** *(if any)*:___________

Date of birth:_______/_______/________

Gender: ☐ Male ☐ Female ☐ Not Disclosed

Last four digits of your Social Security number: ____________________________ *(for student identification)*

or Non-US National Identifier *(if applicable)*: ____________________________

Ethnicity:
(Submission of this information is purely voluntary and refusal to provide it will have no effect on your student or internship experience)

☐ Native American or Alaska Native ☐ Asian ☐ Black or African American
☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ Two or More Races ☐ Not Disclosed

Currently employed by Intermountain Nevada? ☐ Yes ☐ No

E-mail: ______________________________________ **Phone:** __________-___________-_____________

Partial home address: City: ___________________________ State: _________

Emergency contact: Name: ____
Phone: __________-___________-________________

School: ______________________________________ **Program:** _________________________________

Student ID number: ____________________________ **Estimated graduation date:**____________________

School Instructor: *(if any)* ________________________

Intermountain clinic: ____________________________

If known, Intermountain supervisor/preceptor: _____________________________

Observation dates: Start:______/______/______ End:______/______/______

Total hours required for this observation: ___________

NOTE: Upon completion of this profile, you will be provided a student ID badge. ID badges must be returned at the end of your observational experience or each semester if your experience extends over several weeks. Please check with the Student Programs Coordinator for ID badge retrieval instructions.

If you are also an employee of Intermountain, your employee ID badge must not be worn while you are functioning as a student.

Intermountain Health

Intermountain Medical Holdings of Nevada
Pre-requisite Testing Attestation

Students must complete and attest to the following:

☐ Required immunizations *(as noted in this packet)*

The following data is required by the CDC:

☐ Flu immunization *(seasonal)*

Date of current vaccination *(mm/dd/yyyy)*: _____/_____ /_______

Exemption for any immunization:

☐ Medical Exemption ☐ Religious Exemption

Date exemption approved by school: *(mm/dd/yyyy)*: _____/_____ /_______

The following information is voluntary. If you choose not to disclose, please indicate below.

The Centers for Disease Control and Prevention (CDC) require hospitals to continue reporting COVID-19 vaccination status of all health care personnel. Your responses are voluntary but help Intermountain fulfill the CDC's requirement in reporting this information.

☐ I choose not to disclose this information.

COVID-19 immunization:

Initial vaccine

Name of vaccine manufacturer:

☐ Pfizer ☐ Moderna ☐ Novavax ☐ Johnson & Johnson (no longer available)

☐ Other: ____________ ☐ Unknown

1st dose *(mm/dd/yyyy)*: _____/_____ /_______ ☐ Date unknown

2nd dose, if required by manufacturer

Name of vaccine manufacturer:

☐ Pfizer ☐ Moderna ☐ Novavax ☐ Johnson & Johnson (no longer available)

☐ Other: ____________ ☐ Unknown ☐ N/A

2nd dose *(mm/dd/yyyy)*: _____/_____ /_______ ☐ Date unknown

Booster – most recent

Name of vaccine manufacturer:

☐ Pfizer ☐ Moderna ☐ Unknown

(mm/dd/yyyy): _____/_____ /_______ ☐ Date unknown

____

Student Name (printed)

______________________________ ________________

Signature Date

____

School Affiliation

Intermountain Health

Intermountain Medical Holdings of Nevada
ACCESS AND CONFIDENTIALITY AGREEMENT

SECTION 1.O. PURPOSE AND DEFINITION

1.1 **Purpose of this Agreement**. Federal and state laws, as well as Intermountain Medical Holdings of Nevada ("Intermountain") policies, protect Confidential Information, assure that it remains confidential, and permit it to be used for appropriate purposes. Those laws and policies assure that Confidential Information, which is sensitive and valuable, remains confidential. They also permit you to use Confidential Information only as necessary to accomplish legitimate and approved purposes. You may need access to Confidential Information because you have one of the following roles:

A. An Intermountain Workforce member as defined by the Health Insurance Portability and Accountability Act (HIPAA), which includes volunteers (a "Workforce Member"); or
B. An Intermountain-affiliated or Intermountain-credentialed Provider (a "Provider"); or
C. A vendor or agent of Intermountain (a "Vendor" or "Agent"); or
D. Any other authorized person who uses Intermountain resources and/or has access to Intermountain information ("Resource User").

1.2 **Definition**. "Confidential Information" means data proprietary to Intermountain, other companies, or other persons, plus any other information that is private and sensitive and which Intermountain has a duty to protect. You may learn or access Confidential Information through oral communications, paper documents, computer systems, or through your activities at or with Intermountain. Examples of Confidential Information include the following information that is maintained by, or obtained from, Intermountain:

A. An individual's demographic, employment (except that this does not prevent individuals from discussing their terms and conditions of employment), or health information (including Protected Health Information);
B. Peer-review information;
C. Intermountain's business information, (e.g., financial and statistical records, strategic plans, internal reports, memos, contracts, peer review information, communications, proprietary computer programs, source code, proprietary technology, etc.); and
D. Intermountain's or a third-party's information (e.g., computer programs, client and vendor proprietary information, source code, proprietary technology, etc.).

SECTION 2.0. YOUR DUTIES UNDER THIS AGREEMENT

2.1 **Principal Duties**. To qualify to access or use Confidential Information, you will comply with the laws and Intermountain policies governing Confidential Information. Your principal duties regarding Confidential Information include, but are not limited to, the following:

A. Safeguard the privacy and security of Confidential Information;
B. Use Confidential Information only as needed to perform your legitimate and Intermountain-approved responsibilities. This means, among other things, that you will not:
   (1) Access Confidential Information for which you have no legitimate need to know.
   (2) Divulge, copy, release, sell, loan, revise, alter, or destroy any Confidential Information except as properly authorized within the scope of your legitimate and Intermountain-approved responsibilities; or
   (3) Misuse Confidential Information.
C. Safeguard, and not disclose, any Intermountain username and password, access codes, or any other authorization that allows you to access Confidential Information. This means, among other things, that you will:
   (1) Accept responsibility for all activities undertaken using your Intermountain username and password, access codes, and other authorization; and
   (2) Report any suspicion or knowledge that you have that your Intermountain username and password, access codes, authorization, or any Confidential Information has been misused or disclosed without Intermountain's permission (Report this suspicion or knowledge to the Intermountain Compliance Hotline at 1-800-442-4845, or, if you are a member of Intermountain's Workforce, to your supervisor or facility compliance officer.);
D. Not remove Confidential Information from an Intermountain facility unless necessary for your legitimate and Intermountain-approved responsibilities (If removal of Confidential Information from an Intermountain facility is necessary, you will use reasonable and appropriate physical and technical safeguards-such as encrypting electronic Confidential Information or ensuring Confidential Information is not left in plain sight in a car.);
E. Report activities by any individual or entity that you suspect may compromise the confidentiality of Confidential Information (To the extent permitted by law, Intermountain will hold in confidence reports that are made in good faith about suspect activities, as well as the names of the individuals reporting the activities.);
F. Not use or share Confidential Information after termination of your role that triggered the requirement to sign this Agreement (For example, if you are a Workforce Member, when you leave Intermountain's Workforce; if you are a Provider, when you lose your privileges at an Intermountain facility or your privileges to access Confidential Information; and if you are a Vendor or Agent, when you finish your assignment or project with Intermountain or when your company stops doing business with Intermountain, whichever is first.); and
G. Claim no right or ownership interest in any Confidential Information referred to in this Agreement.

SECTION 3.0. VIOLATION OF DUTY - CHANGE OF STATUS

3.1 **Responsibility**. You are responsible for your noncompliance with this Agreement.

3.2 **Discipline**. If you violate any provision of this Agreement, you will be subject to consequences, including but not limited to, the following:

A. If you are a Workforce Member, dismissal as a member of Intermountain' s Workforce, loss of employment with Intermountain, termination of your ability to access Confidential Information, and legal liability;

B. If you are a Provider, Vendor, Agent, or Resource User, discipline, including revocation of your ability to access or use Confidential Information, and legal liability.

3.3 **Relief**. Any violation by you of any provision of this Agreement will cause irreparable injury to Intermountain that would not be adequately compensable in monetary damages alone or through other legal remedies, and will entitle Intermountain to the following:

A. If you are a Workforce Member, Vendor, Agent, or Resource User, preliminary and permanent injunctive relief, a temporary restraining order, and other equitable relief in addition to damages and other legal remedies; or

B. If you are a Provider, a court order prohibiting your use of Confidential Information except as permitted by this Agreement, and Intermountain may also seek other remedies.

3.4. **Authority**. Intermountain may terminate your access to Confidential Information if your status as a Workforce Member, Provider, Vendor, Agent, or Resource User changes, if Intermountain determines that to be in the best interests of Intermountain' s mission, or if you violate any provision of this Agreement.

SECTION 4.0. CONTINUING OBLIGATIONS

4.1 **Continuing Obligations**. Your obligations under this Agreement continue after termination of your relationship with Intermountain as a Workforce Member, Provider, Vendor, Agent, or Resource User.

Printed Name: ______________________________

Signature: ______________________________ Date: ______________

Revised: 6/2017

Student/Trainee Confidentiality Guideline

Summary of Intermountain's Privacy Policies

Protecting patients' privacy has always been an ethical requirement at Intermountain Medical Holdings of Nevada ("Intermountain"). It is also a federal law that care providers protect and use patient information only for certain purposes. As a student or trainee in Intermountain facilities, we require that you abide by our privacy practices. If you have questions about Intermountain's privacy practices, please contact your instructor or Intermountain's Corporate Compliance Hotline at 1-800-442-4845.

Handling Protected Health Information

Protected Health Information includes all medical, billing, and payment records that identify patients. Paper records, electronic records, and oral communication can contain protected health information. Failure to properly protect patient information may result in:

- Verbal or written warnings.
- Suspension or expulsion from your educational institution (if student).
- The termination of your educational experience or training at Intermountain.
- Legal liability for yourself, your educational institution (if student), employer (if professional trainee), and/or Intermountain.

We Do

- Follow Intermountain procedures for the release of protected health information.
- Limit the sharing of protected health information by taking precautions such as not having conversations about a patient in public areas.
- Keep medical, billing and payment records in secure areas or on secure computer systems.
- Ask questions when we are not sure if it is appropriate to release information.

We Don't

- Share patient information unless it is for legitimate business or patient care purposes.
- Share more health information than is appropriate for the situation.
- Share passwords.
- Use data that identifies a specific patient in a presentation.
- Access patient records unless we have a legitimate assignment to do so.
- Make copies of protected health information unless authorized to do so.
- Use personal cell phones to photograph patients.
- Share information about patients, even non-identified patients, with family members, friends, or on social media sites.

Patients' Rights

- Federal regulations define specific patient rights. To follow these regulations, Intermountain:
- Ensures that a patient can get copies of Intermountain's Notice of Privacy Practices that explains how we may use and share protected health information and the patient's rights.
- Allows patients to inspect and obtain a copy of their health information as permitted by law.
- Accommodates requests by patients in how they want us to communicate with them.
- Allows patients to seek a restriction on the use of their protected health information by Intermountain.
- Allows patients to request additions or corrections to their health information.
- Tracks occasions when we share protected health information outside of Intermountain for certain purposes and provide a list of these disclosures to a patient on request.
- Provides a patient with the contact information for Intermountain's Privacy Office and/or the U.S. Department of Health and Human Services when an individual wishes to file a complaint.
- Informs the patient if there is a breach of their protected health information.
- Will not take action against a patient who files a legitimate privacy related complaint with us or the U.S. Department of Health and Human Services.

I acknowledge I have read and understand this document:

____
Student Name (printed)

____________________ ____________
Signature Date

____
School Affiliation

Intermountain Health

Medical Incident and Disease Exposure
Student Training Release of Liability

to be submitted to Intermountain Medical Holdings of Nevada ("Intermountain')
prior to Commencing any Required onsite Training Activity

Student Name: ____ Phone #: ____________________

Name of School/Institution: ________________________________ Phone #: ____________________

School/Institution Training Program: __________________________

Clinic(s): ____

My initials signify I have read, understand, and agree with the following:

____
initial

I understand that there are inherent potential health risks associated with my onsite educational experience ("Training Program") in the clinical learning environment at Intermountain; these risks remain and/or may be increased as they relate to, but are not limited to, injuries, unintended accidents, and communicable disease exposure (e.g., tuberculosis, HIV, COVID-19, etc.). In consideration of being allowed to participate in a Training Program at Intermountain I do hereby waive, release, and forever discharge Intermountain and its officers, agents, employees, representatives, executors, and all others from any and all responsibilities or liability from injuries or damages from my participation in the Training Program. I do also hereby release all of those mentioned and any others acting upon their behalf from any responsibility or liability for any injury or damage to myself, arising out of or connected with my participation in the Training Program.

____
initial

I understand that if I choose not to or am unable to resume my Training Program as it becomes available, I may request a leave of absence from my School/Institution to be allowed to complete my Training Program at a later date. I understand that this may impact my timeline for progression toward graduation. I further understand that my return to my Training Program is dependent upon agreement to my return by Intermountain. Granting a leave of absence is at the sole discretion of my School/Institution.

____
initial

I understand that I am encouraged not to resume the Training Program if I feel I am at increased risk due to personal or health issues, and that I may request a leave of absence from my School/Institution to be allowed to complete my Training Program at a later date upon agreement to my return by Intermountain. I further understand that in granting a leave of absence my School/Institution may choose to alter the timeline of my progression toward graduation or to substitute an equivalent activity to fulfill graduation requirements. Granting a leave of absence is at the sole discretion of my School/Institution.

____
initial

I understand that I am only permitted to resume the Training Program if I do not have symptoms of illness and receive approval by Intermountain.

____
initial

I understand that if I develop symptoms of illness, I must contact Intermountain and must comply with all directions related to Intermountain infectious disease protocols. I must also simultaneously contact my respective clinical team, course director(s), coordinator(s) and, as appropriate, my School/Institution's representative.

____
initial

I understand my right to disease testing and how to access/receive appropriate testing in the event I develop symptoms suggestive of a communicable disease infection. I also understand that I may be responsible for any costs associated with such testing.

____
initial

I agree to comply with the policies and procedures, including health screening practices, for entry into any Intermountain facility.

________ I understand and agree that if I have participated in recent activities* that place me at increased risk for a communicable diseases exposure and subsequent infection, I might be required to complete a period of quarantine in accordance with current CDC, Utah Department of Health, or Intermountain policies prior to participating in any Training Program.
initial

*Examples include, but are not limited to: unprotected close contact with individuals who have a communicable diseases infection; unprotected close contact with individuals with an unknown communicable disease status (such as during extended travel); unprotected close contact with extended family members or social acquaintance; among other activities with potential risk for a communicable diseases exposure.

________ I understand that while in the clinical environment at Intermountain, I must follow the safety measures and infectious disease protocols such as appropriate hand hygiene at all times.
initial

________ If required for my Training Program, any PPE provided by the School/Institution or myself (i.e. masks) must be approved prior to use by Facility Infection Prevention or Industrial Hygiene teams.
initial

________ If contagious disease known or as required by Intermountain, I understand that when examining patients, I must ask them to wear a mask or cover their nose and mouth.
initial

________ I attest that I have or will complete any and all approved training required by Intermountain.
initial

________ I understand that failure to comply with Intermountain's policies, procedures, expectations, training, and practices outlined in this document will automatically suspend me from participating in a Training Program at Intermountain. Intermountain will report this suspension to my School/Institution and will provide full documentation of my behavior to my School/Institution's disciplinary and professionalism committees.
initial

________ I understand any exception to this document needs approval by Intermountain.
initial

Signature of Student: ____ Date: __________________

Intermountain Medical Holdings of Nevada
Observation Student IMMUNIZATION Requirements

These requirements may be revised as mandated by the Centers for Disease Control and Prevention ("CDC") or Intermountain Medical Holdings of Nevada ("Intermountain"). The student will provide documentation of immunizations immediately upon request by Intermountain.

1. Tuberculosis screening requirements. **One of the following is required and must be completed within 60 days prior to the student's observational start date**. There are no exemptions or waivers for TB testing.
   (a) 2-step TST (two separate Tuberculin Skin Tests, aka PPD tests) is placed no sooner than seven (7) days apart and no longer than twelve (12) months apart. The second skin test must be administered and read within the 60-day requirement.

   (b) One (1) QuantiFERON Gold blood test with negative result.

   (c) One (1) T-SPOT blood test with negative result.

   If previously positive to any TB test, student/worker must complete a symptom questionnaire and have a chest x-ray read by a radiologist with a normal result. Chest x-ray must have been taken within the previous 6 months. If chest x-ray is abnormal, the student needs to be cleared by their physician or local health department before beginning their observational experience at an Intermountain clinic.

2. Measles (Rubeola), Mumps and Rubella requirement. One of the following is required:
   (a) Proof of two (2) MMR vaccinations.

   (b) Proof of immunity to Measles (Rubeola), Mumps, Rubella through a blood test prior to immunization.

3. Tdap requirement:
   (a) Proof of one (1) Tdap vaccination after age ten.

4. Varicella (Chicken Pox) requirement. One of the following is required:
   (a) Proof of two (2) Varicella vaccinations.

   (b) Proof of immunity to Varicella through a blood test prior to immunization.

5. Flu Vaccination requirement:
   (a) Proof of current, annual influenza vaccination. Flu season generally runs from October 1 through March 30. These dates may vary as determined by Intermountain.

6. Hepatitis B. The Hepatitis B series should be offered to anyone who is at risk for an occupational exposure, which is defined as someone with a reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of their duties. One of the following should be performed:
   (a) Documentation of three (3) Recombivax HB or Engerix-B Hepatitis B vaccinations (dose 2 given at least one month after dose 1, and dose 3 given at least five months after dose 2) and HBsAb blood test with "Positive" or "Reactive" result.

   (b) Documentation of three (3) Recombivax HB or Engerix-B Hepatitis B vaccinations (dose 2 given at least one month after dose 1, and dose 3 given at least five months after dose 2) given more than 8 weeks prior to start date with no documented blood test results (no blood test is required, but a baseline titer should be run immediately if the person has a significant exposure to blood or body fluids).

   (c) HBsAb blood test with "Positive" or "Reactive" result.

   (d) Documentation of six (6) Hepatitis B Vaccinations with HBsAb blood test result of "Negative" or "Not Reactive" (this person is considered a "Non-Responder").

   (e) Documentation of two (2) Heplisav B vaccinations given at least 4 weeks apart and HBsAb blood test with "Positive" or "Reactive" result. Documentation of two (2) Heplisav B vaccinations given at least 4 weeks apart with no documented blood test results (no blood test is required, but a baseline titer should be run immediately if the person has a significant exposure to blood or body fluids).