



Student/Volunteer Data Form

Chadron Community Hospital & Health Services is "An Equal Opportunity Employer". This necessary information is collected by the Human Resource Office, is confidential, and is in no way used for discriminating purposes, and is used in reporting statistical data.

Personal Information

Full Name: _____
Last First Middle

Home Address: _____
No. Street City State Zip

Main Phone: () _____ Other Phone: () _____

Social Security Number: _____ Birth Date: _____

Race: _____ E-Mail: _____

Department shadowing/Volunteering: _____

Name of School Attending: _____

Graduation Date: _____

Career Interests: _____

Are you interested in learning about career opportunities at Chadron Community Hospital?

Yes, please contact me with more information.

No, I am not interested.

Emergency Contact:

Full Name: _____ Relationship: _____

Address: _____ Main Phone: _____

Date _____ Student/Volunteer _____
Signature

Date _____ Legal Guardian _____
Signature - If under the age of 19.



HIPAA

Acknowledgment

As a Student/Volunteer performing duties at Chadron Community Hospital & Health Services, you will have access to the protected health information of our patients. Federal and State Laws, including HIPAA and our policies & procedures, protect the privacy and security of this protected health information. It is illegal for you to use or disclose protected health information outside the scope of your student/volunteer duties at Chadron Community Hospital & Health Services. This includes oral, written, or electronic uses and disclosures.

Guidelines:

- You may use protected health information as necessary to carry out your duties as a student or volunteer.
- You may share protected health information with other health care providers for treatment purposes.
- You may NOT photocopy protected health information.
- You may NOT photograph patients.
- You must access only the minimum amount of protected health information necessary to care for patient or to carry out an assignment.
- You may NOT record protected health information (such as names, diagnoses, dates of birth, addresses, phone numbers, Social Security numbers, etc.) on any assignments you may need to turn in to your instructor, reports you may need to turn in to your program, or forms you may need to take with you.
- You may only access the protected health information of patients for whom you are caring/volunteering when there is a need for protected health information.
- Be aware of your surroundings when discussing protected health information.
- When disposing of any documents with protected health information, do NOT put them into a waste can. Place discarded documents with protected health information into shredders or containers marked for shredding.
- If you have questions about the use or disclosure of protected health information, contact Chadron Community Hospital & Health Services Human Resources Department.

I have reviewed and understand the information presented. I realize that there are civil and criminal penalties for the unauthorized use and disclosure of protected health information. I will abide by the guidelines when performing my duties at Chadron Community Hospital & Health Services.

PRINT: Student/Volunteer Name

Date

SIGNATURE: Student/Volunteer Name



Confidentiality

I understand that I have the responsibility for maintaining strict confidentiality of information shared with me or acquired by me as a part of my routine duties and access at Chadron Community Hospital & Health Services. Any patient information, computer passwords, confidential information about an employee, physician, or management and all financial information regarding Chadron Community Hospital & Health Services that is made available to me as a student/volunteer of Chadron Community Hospital & Health Services is for my professional and authorized use only. I understand that such information may be discussed only as needed to perform the duties and responsibilities of my position.

In consideration of my education opportunity with Chadron Community Hospital & Health Services, and as an integral part of the terms and conditions of my education, I hereby agree, pledge and undertake that I will not, at any time during my education opportunity with Chadron Community Hospital & Health Services, or at any time after my education opportunity ends, access or use personal health information (PHI), or reveal or disclose to any persons or entities within or outside of Chadron Community Hospital & Health Services, any personal health information (PHI) except as may be required in the course of my duties and responsibilities and in accordance with all applicable legislation, corporate and departmental laws, rules, regulations or policies governing the release of information.

I understand that my obligations outlined above will continue after my education opportunity with Chadron Community Hospital & Health Services ends and, **I further understand** that my obligations concerning the protection of the confidentiality of personal health information (PHI) relate to all personal health information (PHI), that I have acquired through my employment with Chadron Community Hospital & Health Services.

I also understand that unauthorized use or disclosure of confidential information will result in corrective action up to and including, but not limited to termination of education opportunity with Chadron Community Hospital & Health Services, the imposition of sanctions or fines pursuant to Nebraska and Federal laws, and a report to all my professional regulatory bodies.

PRINT: Student/Volunteer Name

Date

SIGNATURE: Student/Volunteer Name