Job Shadow Date:_____

Confidential Job Shadow Candidate Information

Name:_____ DOB:_____

Address:_____

Phone #:_____ Cell #_____

Emergency Alert for Allergies:_____

_____

Emergency Contact Information

Name:_____ Phone #:_____

Address:_____

Relationship:_____

Family Physician:_____ Phone #:_____

Family Dentist:_____ Phone #:_____

Preferred Hospital:_____

Section I: Confidentiality & HIPAA

As a job shadow participant of Orthopedic Associates, I agree to observe the privacy rights of the patients and their medical information as regulated by the Federal Health Insurance Portability and Accountability Act of 1996. This means that any individual medical data or information that I may hear, see, or observe is not to be disclosed to any individual outside the intent and purpose of the job shadow visit. The information may be discussed with the people directly involved in conducting the visit. I understand the need for and agree to maintain confidentiality. This means I cannot read the patient's chart, cannot tell others outside of Orthopedic Associates that this person is a patient at Orthopedic Associates, and cannot tell anyone any information about the patient. Furthermore, I understand that if I disclose patient specific data and information to any unauthorized individual, I may be liable for severe fines and penalties. *Initial:* _____

Section II:

I understand that if I have a known infectious disease, I shall not place myself in areas in which I would jeopardize others at Orthopedic Associates. If I become aware that I have or suspect a serious infectious disease, I will notify my contact person at Orthopedic Associates. Initial: _____

Section III: Orthopedic Associates Policy and Behavior

I, the undersigned individual, understand that I am participating in this job shadowing visit as a volunteer to gain a deeper understanding about careers in the medical field and this visit is a privilege for me. I expect no compensation for this job shadowing experience.

I will conduct my job shadowing activities at Orthopedic Associates only under the supervision of the designated Orthopedic Associates employee. I will support the philosophy of Orthopedic Associates during my job shadow experience.

I agree to support Orthopedic Associates' policy of professional appearance. T-shirts, shorts, jeans, capris, sandals, and open-toed shoes are not allowed. The dress code for shadowing is business casual or scrubs. Each person must be neat, clean and devoid of strong perfumes or body odors. Tattoos must not draw undue attention. If tattoos may be deemed as a distraction, they should be covered.

I agree to conduct my job shadowing activities in a professional manner. I understand that smoking, vaping, use of illegal drugs or alcohol, or foul language is not allowed on Orthopedic Associates property.

I agree to arrive for my job shadowing hours at the scheduled time at the designated location. I understand that the listed policies and behaviors of Orthopedic Associates must be adhered to, or I may be asked to leave and not return for any shadowing opportunities in the future.

Signature of job shadow candidate: _____ Date: _____

Printed name of job shadow candidate: _____

Signature of parent/guardian: _____ Date: _____

(If visitor is under years of age)

Printed name of parent/guardian: _____

OASWO
6551 Centerville Business Pkwy
Suite 120
Centerville, OH, 45459

937-428-0400
937-438-8630

Confidentiality and Security Agreement For Workforce Members

It is the responsibility of all OA (hereafter referred to as the 'Organization') workforce members to protect the privacy, security, and confidentiality of any information to which they are given access.

Workforce members (including employees, trainees, volunteers, faculty and other persons) who perform work for OA utilizing its computing systems, resources, and data are responsible for the confidentiality and security of all protected health information (PHI). Additionally, the Organization must assure the confidentiality of its internal human resources, payroll, fiscal, research, internal reporting, strategic planning, communications, computer systems and management information.

I understand and acknowledge the following:

In the course of my relationship with the Organization, I understand that I may come into the possession of this type of PHI or confidential information. I will access and use this information only when it is necessary to perform job-related duties and in accordance with the Organization's privacy and security policies. I further understand that I must sign and comply with this Agreement in order to obtain authorization for access to PHI or other confidential information.

I understand and agree to adhere to the following:

1. I will not disclose or discuss any PHI or other confidential information with others, including friends or family, who do not have a need to know it.

2. I will not in any way divulge, copy, release, sell, loan, alter, or destroy any PHI or other confidential information except as properly authorized.

3. While discussing PHI or other confidential information, I will take reasonable measures to prevent others who are not authorized, from overhearing the conversation. It is not acceptable to discuss PHI inappropriately even if the patient's name is not used.

4. I will not make any unauthorized transmissions, inquiries, modifications, or deletions of PHI or other confidential information.

5. I agree that my obligations under this Agreement will continue after termination of my relationship with the Organization.

6. Upon termination of my relationship with the Organization, I will immediately return any documents or media containing PHI to the Organization.

7. I understand that I have no right to any ownership interest in any information accessed or created by me or others during my relationship with the Organization.

8. I will act in the best interest of the Organization and in accordance with HIPAA regulations at all times during my relationship with the Organization.

FORM Vs

9. I understand that HIPAA and other privacy violations can be enforced on individuals; therefore, I must manage all PHI and other confidential information in compliance with federal and state statutory and regulatory requirements and according to Organization policies and procedures.

10. I understand that violation of this Agreement may result in civil action by the Organization or by a governmental authority.

11. I understand that violation of this Agreement may result in immediate termination of my relationship with the Organization.

12. I understand that any Privacy, Confidentiality or Security violation; suspected violation or incident that I discover or become aware of will immediately be reported to the Organization's Privacy Officer.

13. I will only access or use systems or devices I am officially authorized to access, and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

14. I will only access PHI related to Patients for which I have a defined relationship. I will not inappropriately access, use or disclose PHI.

15. I understand that I should have no expectation of privacy when using the Organization's Information Systems. The Organization may log, access, review, and otherwise utilize information stored on or passing through its systems, including email, in order to manage systems and enforce security.

16. I will utilize the Organization's workstation security measures such as locking up storage media when not in use; using screen savers appropriately; positioning screens away from public view and logging off the workstation when I will be away from it for any extended period of time.

17. I will follow Organizational policies for secure electronic communications by transmitting PHI only to authorized entities, in accordance with approved security standards.

18. I will:
    a. Use only my officially assigned User-ID and password .
    b. Use only approved licensed software.
    c. Use a device with virus protection software.

19. I will never:
    a. Share/disclose User-IDs or passwords; PINs, or access codes.
    b. Use tools or techniques to break/exploit security measures.
    c. Connect to unauthorized networks through the systems or devices.

I will notify the Organization's Privacy Officer or Security Officer if my password has been seen, disclosed, or otherwise compromised, and will report any activity that violates this Agreement, the Organization's privacy and security policies, or any incident that could have any adverse impact on PHI or other confidential information.

Signature Page Follows on Reverse

FORM Vs

NAME of Workforce Member or Job Shadow Candidate

_____

SIGNATURE of Workforce Member **or Job Shadow Candidate** **DATE**

_____

JOB TITLE, DEPARTMENT/ORGANIZATION AFFILIATION

☐ Provide copy of this Agreement to the workforce member.

Copy provided on: _____/_____/_____ by _____
Date Name of Supervisor, Manager or designee

_____
Signature of Supervisor, Manager or designee

NOTE: File the signed original Agreement in departmental personnel or academic file; retain for 6 years, the minimum HIPAA-defined timeframe.

FORM Vs

M E M O R A N D U M

TO: Employee or Job Shadow Candidate

RE: Internet and Computer Use Policy

It is necessary for us to address our expectations of all job shadow candidates with respect to Internet and computer use at OA.

Computers and computer accounts are provided by OA to assist in the performance of their jobs. The computer system belongs to OA and may be used only for business purposes. OA reserves the right to monitor employee's (and any person job shadowing) computer and Internet usage at any time. Material that is fraudulent, harassing, embarrassing, sexually explicit, profane, obscene, intimidating, defamatory or otherwise unlawful or inappropriate may not be sent or received by e-mail or other form of electronic communication (such as bulletin board systems, newsgroups, chat groups) or displayed on or stored in OA computers. Employees (and any person job shadowing) encountering or receiving this kind of material should immediately report the incident to a manager. Employees (and any person job shadowing) should not have an expectation of privacy in anything they create, store, send, or receive on the OA computer system. Employees (and any person job shadowing) discovered violating this policy, "surfing" the Internet or otherwise utilizing OA's computers for non-business purposes shall be subject to disciplinary action, up to and including termination of employment and/or removal from company premises.

Please direct any questions regarding this policy to a supervisor. All employees (and any person job shadowing) are required to sign and date below to acknowledge that you received, read and understand this policy. Thank you for your attention to this important matter.

_____ _____

DATE EMPLOYEE'S/ JOB SHADOW CANDIDATE SIGNATURE

_____

PRINT EMPLOYEE'S/ JOB SHADOW CANDIDATE NAME

NOTICE: FIREARM-FREE WORKPLACE

Please be advised that Orthopedic Associates has posted, on all entrances to all of its offices, signage notifying all people, including employees, that all firearms,[1] including concealed firearms, are not permitted on the premises, regardless of whether the individual has a license to carry a concealed firearm.

Any person, including an employee, who knowingly violates the posted prohibition on firearms is guilty of criminal trespass and is guilty of a misdemeanor of the fourth degree.

All employees of Orthopedic Associates are required to follow this statute's provisions.

Please sign and print your name below indicating that you have received and understand this Notice.

_____

Employee's (or Job Shadow Candidate) Name [print]

_____

Employee's Signature

_____

Date

OHIO REVISED CODE 2923.126(C)(3)(A)

[T]he owner or person in control of private land or premises, and a private person or entity leasing land or premises owned by the state, the United States, or a political subdivision of the state or the United States, may post a sign in a conspicuous location on that land or on those premises prohibiting persons from carrying firearms or concealed firearms on or onto that land or those premises. Except as otherwise provided in this division, a person who knowingly violates a posted prohibition of that nature is guilty of criminal trespass in violation of division (A)(4) of section 2911.21 of the Revised Code and is guilty of a misdemeanor of the fourth degree.

[1] Firearm is defined as a weapon, a pistol or rifle, whether loaded or unloaded, capable of firing a projectile and using an explosive as a propellant.

DRUG FREE WORKPLACE AND SUBSTANCE ABUSE POLICY

The use of illegal drugs and alcohol, and the abuse of legal prescription pharmaceuticals, account for tremendous losses in efficiency, attendance and costs of company-provided health care. These abuses also diminish the safety of all employees and visitors, impair the reputation of Orthopedic Associates, and violate state and federal laws. In addition, the use and abuse of drugs and alcohol can have severe health consequences and lead to the destruction of family unity. For these reasons, Orthopedic Associates has adopted a zero tolerance drug and alcohol policy. With this policy, it is the intention of the company to use every lawful means to establish and maintain a drug and alcohol free workplace.

Illegal drugs are substances that are controlled or outlawed, are not obtainable by lawful methods, or are legally obtainable but were not obtained in a lawful manner.

This policy prohibits the use, sale, manufacture, distribution or possession of alcohol or illegal drugs, drug paraphernalia or any combination thereof, on any company premises or at any location where the job shadow candidate is observing employees performing his/her job duties. This includes company vehicles on or off company premises. Violation of this policy will subject the job shadow candidate to be removed from company premises, and may have legal consequences.

If a job shadow candidate is using medication prescribed by a licensed physician, he/she is responsible for obtaining assurances from that physician that the medication will not impair the job shadow candidate's judgment or ability to safely and efficiently observe employees at Orthopedic Associates.

Any employee or job shadow candidate who knows or believes that there is unlawful involvement by other employees, vendors or guests with illegal drugs or alcohol contrary to this policy, should immediately refer this information to his/her supervisor or to the HR Director. Orthopedic Associates will utilize all lawful investigative techniques in response to this information. Evidence obtained by the company of the unlawful use, manufacture, trafficking, distribution or possession of controlled substances will be provided to the appropriate law enforcement authorities.

All job shadow candidates must abide by the terms of this policy and must report any convictions under a criminal drug statute for violations occurring on or off company premises. This report must be made within five days of a conviction and is mandated by the Drug Free Workplace Act of 1988.

Acknowledgement of Receipt
of
Drug Free Workplace Policy

Signing this form acknowledges that the employee or job shadow candidate has received a copy of Orthopedic Associates' Drug Free Workplace Policy, has had the opportunity to discuss the policy and have questions answered, and understands all of the provisions of the policy. Although it reflects Orthopedic Associates' current policy regarding substance abuse, it may be necessary to make changes from time to time to best serve the needs of our organization.

By my signature below, I acknowledge that I have received a copy of the Drug Free Workplace Policy of Orthopedic Associates'. I understand that it is my obligation to read, understand and comply with the procedures and provisions contained within this policy.

_____ _____

Printed Name Signature

_____

Date

Smoke Free Policy

All Orthopedic Associates locations are SMOKE FREE facilities. No smoking and/ or vaping is allowed in or around the facility or on the campus of any office location of OA at any time. Any employee/job shadow candidate caught violating this policy will be subject to disciplinary action which could include immediate termination/ removal from company premises.

_____ _____

Signature Date

Body Tattoos & Piercing

It is the policy of OA as a professional medical practice that an employee's (and job shadow candidate's) appearance should be appropriate to the professional workplace. Since image is communicated to patients and the public in general primarily through our employees, OA will require employees (and job shadow candidates) to maintain a professional appearance during scheduled work hours, the following guidelines should be followed:

1. Visible body piercing (with the exception of ears- excluding ear bars) is not appropriate (i.e. no tongue, eye, lip or nose piercing).
2. Tattoos, if visible, must not draw undue attention to the individual, when appropriate please cover with short/long sleeve shirts under uniforms or long pants or socks/shoes.

Procedure:

If an employee (or job shadow candidate) reports to work in a manner that the physician or management team deems inappropriate, the employee (or job shadow candidate) will be instructed to return home to make the necessary changes.

Signature_____ **Date**_____

Privacy Officer: Heidi Sippel-Haas

6551 Centerville Business Pkwy, Suite 120, Centerville, OH 45459

hsipple-haas@oaswo.com

Confidentiality and non-disclosure for visitors and non-workforce members

This form comprises a strict confidentiality and non-disclosure agreement between all visitors and non-workforce persons who will be onsite observing operational activities. The purpose of this form is to bind visitors (i.e., Students, trainees, vendors, et al.) so that they do not disclose patient data that they are incidentally exposed to during their visit no matter the length of visit this agreement should remain intact. This agreement is binding at any location operated by any member of the Orthopedic Associates od Southwest Ohio organization (OASWO).

I the undersigned:

Certify that I am visiting this organization for lawful and necessary training, observation, educational, or business practices.

I understand that while I am visiting in this capacity, I may be exposed to confidential information which includes protected health information (PHI), other sensitive or proprietary organization information that is protected by federal HIPAA privacy regulations, other laws or facility policies.

I agree to adhere to the following in guidelines:

- Use of any protected health information or other confidential information is only for the training observational and/or educational purposes of my visit and I will keep the information confidential.
- All patient information as well as information regarding organizational, operational, employees, and human resources are confidential. Any inappropriate viewing discussion or disclosure of this information is a violation of policy and law.
- This information is privileged and confidential regardless of format (I.E. electronic, written, overheard, observed, or any verbal communication.
- Visitors must not attempt to view hear copy or otherwise access any PHI that is not part of the purpose for the visit or authorized by this organization. Any such violations may lead to civil liability and or criminal charges
- Notes must not be taken of any information that includes any PHI.
- Visitors must not attempt to access any PHI or confidential information about themselves, their family or any other person.
- If a visitor accidentally sees, hears, or is otherwise exposed to patient information, he she must not disclose the patient information to anyone. This includes telling another person about patients that were present within our organization.
- Photographing our facility, employees, or patients is prohibited. This includes taking pictures or videos with digital recording devices and/or cell phone cameras.
- Visitor confidentiality obligation continue after the visit to this organization ends.

I understand that I may direct any question I have about my obligations under this confidentially pledge or under any of the policies and applicable laws and regulations related to confidentially to this organizations privacy officer listed above.

Name of Visitor _____

Signature of Visitor _____

Organization affiliation/ reason for visit _____

Date of signature _____