St. Elizabeth Healthcare RYL Health Session Program Agreement

The RYL Health Session at the St. Elizabeth Training and Education Center (SETEC) is a career exploration experience and learning tool in which participants observe St. Elizabeth Healthcare employees in their clinical/work environment. There will be no hands-on patient contact as all tasks are observed. The RYL Health Session takes place over a 7-hour concentrated period in a St. Elizabeth Healthcare department/facility. The department liaison will review the participant's objectives for appropriateness and assist the participant in completing these objectives in so far as the department setting allows.

Participant Responsibilities

A. Respect the rights and confidentiality of patients and families at all times.
B. Sign a confidentiality agreement with St. Elizabeth Healthcare.
C. Adhere to established dress code, including wearing RYL name badge while on the premise.
D. Follow good handwashing techniques and wear personal protective equipment if there is a potential of coming into contact with blood or other body fluids.
E. Inform RYL Program Director and/or volunteers if at any time the participant feels nauseous, dizzy, or otherwise ill during the shadowing activity.
F. At all times remain where directed and leave the areas when requested to do so by administration.
G. Observers are prohibited from all hands-on experiences related to direct patient care. No touching, management, counseling, or therapeutic interaction with patients or families will be allowed.

Learning Objectives

A. Participant will develop an awareness of the technology and procedures used in the career field.
B. Participant will identify skills and knowledge of the profession.
C. Participant will learn about individual and team contributions to the care of the patient.
D. Participant will identify the connection between classroom learning and practical application in the work environment.

Agreement

A. I recognize that observing in the healthcare setting and any complication thereof may be emotionally distressing. I also recognize the primary responsibility of the physicians and personnel is to the patient; therefore, it may not be possible to provide immediate attention to me should the need arise.
B. I understand the patient right to confidentiality, and agree to respect that right, by not disclosing information regarding any patient or regarding the organization/administration.
C. In consideration of the permission granted, I hereby release the physicians, the organization, and its employees from any claims or liabilities, physical injury and/or damage including emotional distress, injury or mental anguish which may be sustained by me or the patient as a result of the presence of myself in the hospital setting.
D. I am age 16 or older. (Please enter your DOB if you have not turned 16: _____)

Participant Signature_____ Date _____

Participant Name (print) _____

St. Elizabeth Healthcare RYL Confidentiality /Non-Disclosure Agreement

Participant Name (Print) _____

As a participant of Regional Youth Leadership, I am responsible for maintaining the confidentiality of information relating to patients/residents/clients and fellow class members. Unless it is necessary to complete my job responsibilities, information about the present condition, performance, or personal affairs of patients/residents/clients or other associates will not be repeated or discussed either inside or outside St. Elizabeth Healthcare.

When confidential information must be discussed in the course of my work, I will use discretion to keep such conversations from being overheard by others who are not directly involved. I am aware that there are both state and federal laws that protect health information and other confidential information from unauthorized access. I also realize careless or thoughtless release of confidential information can result in disciplinary action, including termination and also could result in legal action being taken against St. Elizabeth Healthcare.

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Confidential information includes but is not limited to: (1) information about patient/resident/client's condition or treatment; (2) aggregate clinical data; (3) employee records; (4) employee patient/resident/client records (5) marketing plans; (6) product or service plans; (7) strategies/forecasts; (8) patient/resident/client lists; and/or 9) financial information.

Confidential information can be obtained through hearing it, seeing it, viewing the medical record, or accessing it in the computer system. I agree to abide by the following:

- I agree to keep confidential all information I access.
- I agree to access only that information for which there is a "Business Need to Know." I understand that my access may be monitored.
- I understand that I may not use the St. Elizabeth Healthcare computer system to access the medical records or financial records of myself, my family, my neighbor(s), my co-workers, or anyone, without a business-based reason to do so. I also understand I may not look at paper records of any of these individuals without a business-based reason to do so.
- I agree to protect data at all times, which includes data in electronic, paper, film, images, video, or other forms.
- I will protect data during its creation, entry, processing, distribution, storage, and disposal.
- I agree to protect data from unauthorized access, modification, destruction, or disclosure.
- I understand that upon my termination from St. Elizabeth Healthcare my ability to access St. Elizabeth information will end. I agree that I will not attempt to access St. Elizabeth Healthcare systems or disclose any confidential information to any person or entity after my termination.
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I have read this document and understand that my signature constitutes my acceptance of the terms of the "Confidentiality/Nondisclosure" agreement.

Participant Signature_____ Date _____

St. Elizabeth Healthcare RYL Career Explorer Parent/Guardian Consent Form

- My child has my permission to participate in the RYL Health Session at St. Elizabeth Healthcare/St. Elizabeth Training & Education Center (SETEC).
- I am aware that participation in this program requires travel to St. Elizabeth Healthcare/SETEC and I release St. Elizabeth Healthcare from any liability associated with that travel.
- This is a St. Elizabeth Healthcare sponsored program and my child understands the need for professional and respectful conduct and attire at all times.
- I give permission for my son/daughter to be photographed or videotaped during the program which may be used for promotional or educational purposes.
- Should it be necessary for my child to have medical treatment while participating in the RYL Health Session, I hereby give St. Elizabeth Healthcare staff members permission to use their best judgment in obtaining medical services for my child. I give permission to any attending physician to render whatever medical treatment he/she deems necessary and appropriate.
- In consideration of the permission granted, I hereby release the physicians, the organization, and its employees from any claims or liabilities, physical injury and/or damage including emotional distress or injury or mental anguish which may be sustained by me or the patient as a result of the presence of myself in the hospital setting.
- In the event of an emergency, parents/guardian can be reached at the following phone numbers:
  _____

☐ I agree to the above statements and consent form.

_____ _____

Signature of parent or guardian Date