Southeast Washington Student Intake Packet

St. Mary Medical Center

Kadlec Regional Medical Center

Lindsie Moore, CHC, CLC

Administrative Coordinator &
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Providence

St Mary Medical Center
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PSMMCStudents@providence.org

Michael G. Hood

Supervisor Clinical Education
Navy/Marine Corps Veteran- (FMF)

KADLEC

Kadlec Regional Medical Center
O: 509-210-9639
AcademicServices@kadlec.org

Dear Student,

Thank you for your interest in Providence Health Care. Please complete the packet in full and return to:

- St. Mary: PSMMCStudents@providence.org
- Kadlec: AcademicServices@kadlec.org

Full Name (First, Last, Middle I)	
School Affiliation Rotation Start & End Dates	

COMPLETE STUDENT INTAKE PACKET AND RETURN PROMPTLY

Within this packet you will find the following:

- Acceptable Use Agreement
- Acknowledgement of the Code of Conduct
- Non-Employee Confidentiality and Nondisclosure Statement
- EPIC Request Form – This document must be completed and signed by the student*.

  This document will need to be signed ONLY if you require EPIC or network access. Existing students with EPIC access will need to call 844-922-7548 to reactivate your account if it has been more than 90 days since you last logged in on your first day.
- Providence Corporate Integrity Agreement Compliance Training
  - If not already complete: Register here for your unique training link to be sent to you. Once the training and post-test are completed, include a copy of your Certification of Completion with this packet.
    - (This is required annually, through 5/2027.)
    - ***If you will only participate in student activities at Kadlec exclusively, this training is not required**
- Student Clinical Passport – This document should be completed in its entirety, signed and dated.
  - An academic representative must sign the Student Clinical Passport
- By signing below, you attest that you reviewed the "General SEWA Healthcare Student Orientation" module in full, available on the SEWA Student Portal.

Signature	Printed Name	Date

PACKET PROCESSING

Please send the completed packet to the appropriate contact listed above for the correct location.
A Providence student coordinator will reach out to you once your intake packet has been received.
Thank you and welcome to Providence. We hope your rotation experience with Providence is rewarding!

Reminder: Onboarding documents must be provided to Providence on an annual basis. Thank you!

Providence St. Joseph Health

THE MISSION

AS EXPRESSIONS OF GOD'S HEALING LOVE, WITNESSED THROUGH THE MINISTRY OF JESUS, WE ARE STEADFAST IN SERVING ALL, ESPECIALLY THOSE WHO ARE POOR AND VULNERABLE.

COMPASSION

Jesus taught and healed with compassion for all. –Matthew 4:24

We reach out to those in need and offer comfort as Jesus did. We nurture the spiritual, emotional and physical well-being of one another and those we serve. Through our healing presence, we accompany those who suffer.

DIGNITY

All people have been created in the image of God. –Genesis 1:27

We value, encourage and celebrate the gifts in one another. We respect the inherent dignity and worth of every individual. We recognize each interaction as a sacred encounter.

JUSTICE

Act with justice, love with kindness and walk humbly with your God. –Micah 6:8

We foster a culture that promotes unity and reconciliation. We strive to care wisely for our people, our resources and our earth. We stand in solidarity with the most vulnerable, working to remove the causes of oppression and promoting justice for all.

EXCELLENCE

Whatever you do, work at it with all your heart. –Colossians 3:23

We set the highest standards for ourselves and our ministries. Through transformation and innovation, we strive to improve the health and quality of life in our communities. We commit to compassionate, safe and reliable practices for the care of all.

INTEGRITY

Let us love not merely with words or speech but with actions in truth. –1 John 3:18

We hold ourselves accountable to do the right things for the right reasons. We speak the truth with courage and respect. We pursue authenticity with humility and simplicity.

Kadlec Promise, Mission, Vision & Values

Mission

- To provide safe, compassionate care

Promise

- Know me, care for me, easy my way

Vision

- Health for a better world

Values

- **Safety**-As our highest priority, safety is at the core of every thought and decision
- **Compassion**-We reach out to people in need an give comfort. We nurture the spiritual, physical, and emotional well-being of one another
- **Respect**-We treat everyone with acceptance and honesty, valuing individual and cultural differences
- **Integrity**-We earn the trust of the community through ethical behavior and transparency
- **Stewardship**-We believe that everything entrusted to us is for the common good. We strive to care wisely for our people, our resources, and our community.
- **Excellence**-We hold ourselves accountable to the highest standards of quality and safety
- **Collaboration**-We join together and with others across the community to advance the interest of patients and families

Doing the Right Thing Right

Our Code of Conduct

Our mission, vision, values, and promise provide guidance and inspiration as we deliver quality care, make sound, ethical choices, and meet our organizational goals. As workforce members, we are accountable for the integrity of our decisions and actions on the job. The Code of Conduct provides a foundation of expectations for us as we do our work each day.




Ways to report a concern

- *Discuss the matter or concern with your immediate supervisor*
- *Discuss the matter or concern with your department leader*
- *Discuss with your HR Partner, HR Service Center, or send report via HR Portal*
- *Contact your local or regional compliance or privacy representative*
- *Call the 24/7 Integrity Hotline at 888-294-8455 or use Integrity Online, our Web-based reporting option.*
- *For Caregivers in India:*
  - From an outside line, dial the direct access number: 000-117
  - At the English prompt dial 888-294-8455

You may report concerns anonymously

We adhere to all laws and regulations and are committed to a workplace culture where all individuals are treated with respect and dignity, regardless of protected characteristics, as defined by local, state, or federal law, including but not limited to race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), genetic information, marital status, age, sex (which includes pregnancy, childbirth, breastfeeding and related medical conditions), gender, gender identity, gender expression, sexual orientation, and military and veteran status.

Quality of Care and Patient Safety

We commit to provide the best, *compassionate* care and service every time and strive to meet and exceed national standards for quality and patient *safety*.

Stewardship of Resources

We commit to effective stewardship of resources in support of patient care and organizational goals and only use resources for legitimate business purposes.

Conflicts of Interest (COI) Commitment

We will avoid actual or perceived COI and agree to disclose any outside interests or activities, contracts, and relationships that may be in conflict to the organization. We maintain impartial relationships with vendors, research sponsors, and contracts by not requesting or accepting gifts, cash, or cash equivalents.

Ethical and Legal Standards

We conduct ourselves in a professional and ethical manner in support of *justice* and will perform our job duties in accordance with all federal, state, and local laws.

Safeguarding Patient Information and Protecting Privacy and Confidentiality

We take every precaution to safeguard patient information, and we will treat protected health information (PHI) of all with special care and follow all federal, state, and local laws.

Ethical Conduct of Research

We follow the highest ethical standards and comply with all laws, regulations, guidelines, and ethical directives (where applicable) that govern human, animal, and basic applied science research.

Licensure and Certification

We require all health care and education professionals to follow all federal, state, and local laws applicable to licensing, credentialing, and certification requirements. Individuals on the excluded provider lists cannot work for our organization.

Compliance with Applicable Federal and State Laws and Regulations, and Policies

We ensure *excellence* by requiring all parties that work for or on behalf of an employer within our family of organizations learn and follow all laws, regulations, and policies.

Fair Business Practices

We conduct ourselves ethically, honestly, and with *integrity* at all times.

Reporting Violations and Protection from Retaliation

We will use the appropriate method to report any violation or suspected violations of our code(s), fraud, waste, or abuse as required. Retaliation or harassment will not be tolerated.

ACKNOWLEDGMENT OF COMMITMENT TO THE CODE OF CONDUCT

These standards in the Providence Code of Conduct do not, nor were they intended to, cover every situation you may encounter. They provide only broad guidance that is defined in greater detail by the various policies, standards, procedures and guidelines of Providence, your region and your facility.

Confidentiality and Nondisclosure Statement

Name: _____ Position: _____

I understand that in my involvement with the facility I may have access to information not generally available or known to the public. I understand that such information is confidential and belongs to the facility. Confidential data/ information includes but is not limited to patient, customer, member, provider, group, physician, student, resident, financial, and proprietary information, whether oral or recorded, in any form or medium. Confidential data/information also includes workforce member information that a workforce member does not wish to share. However, nothing in this statement restricts a workforce member's right to disclose wages, hours, and working conditions in accordance with federal and state laws. I understand that information developed by me, alone or with others, may also be considered confidential data/information belonging to the organization in accordance with our policies and procedures.

I will hold any confidential data/information I see or hear in strict confidence and will not disclose or use it except as authorized by the facility.

I will only access the confidential data/information that I need to do my job and will only provide such information to those who need it.

I understand that unless it is a part of my job function, I cannot remove any confidential data/information from the organization without authorization from my core leader and that I must return any such confidential data/information at the end of my employment, engagement or relationship with the facility. I understand that confidential data/information must be stored securely at all times as defined in our policy.

I understand it is my responsibility to become familiar with and abide by applicable laws, regulations, and our policies and protocols regarding the confidentiality and security of confidential data/information.
I understand that email is not a secure, confidential method of communication. I will never send confidential data/information to a personal email account or store it on my personally owned computer or mobile device. When sending messages that include confidential data/information to a non-facility email address as part of my job functions, I must type "#secure#" in the subject line to encrypt the contents of the email. I understand that texting and other messaging are not secure methods to transmit confidential data/information and agree not to use these types of communication methods to transmit such information. I agree to the acceptable use of computer equipment and resources as outlined in policy.

I understand that electronic communication technologies (internet and email) are intended for job-related activities: However, limited personal use is permitted. Personal use is determined as incidental and occasional use of electronic communications technologies for personal activities that should normally be conducted during personal time, such as break periods, or before and after scheduled working hours, and is not in conflict with business requirements of the department. At Providence, internet usage is monitored and audited on a regular basis by our organization. The organization also reserves the right to monitor email and telephone usage.

I understand that this Confidentiality and Nondisclosure Statement does not limit my right to use my own general knowledge and experience, whether or not gained while employed by the facility or partner organization, or my right to use information that becomes generally known to the public through no fault of my own.

I understand that if I breach the terms of this Confidentiality and Nondisclosure Statement or for serious violations of policies related to use or disclosure of confidential data/information including but not limited to viewing of PHI (including demographic information alone) by use of identity look up modules in the electronic health record or by use of other means, for the purpose or personal benefit/curiosity or when there is no business or medical purpose, the facility may institute corrective action up to and including termination of my employment, engagement or relationship with the facility or partner organization.

Signature: _____ Date: _____

Article KB0071722 : Updated 4/2021

Data Access Acceptable Use Agreement for Non-Providence Workforce Members (Attachment A)

Providence Health & Services ("Providence") requires that everyone granted access to our information systems will protect our patients' information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules and other applicable state and federal laws.

I acknowledge that (please initial):

_____Providence is granting me access to systems and information owned or operated by Providence or one of its subsidiaries, and I will have access to confidential information not generally available or known to the public, including protected health information (PHI).

_____Providence will issue me a unique user ID and password. I agree that I am not permitted to share this user ID or password with anyone. I will never share my password or leave it written down for others to find, nor will I utilize user ID and password auto save functionality on any computer or mobile device.

_____I agree to immediately notify Providence by calling the Breach Reporting Hotline 866-406-1290, if I have a reason
to believe that any other person may know my user ID or password.

_____I understand my computer account and password will be considered my computer signature, and I will protect it accordingly. I will keep PHI out of sight and secure it when not in use to prevent unauthorized access.

_____ Federal and state laws protect Providence information to which I will have access, and I will abide by those laws.

I understand what qualifies as PHI and that I am required to comply with the HIPAA Privacy and Security Rules.

_____ I agree that I will not access Providence information for which I have no legitimate need. I will not access my own records or records of my family members. I will only access minimum necessary information for which I have a legitimate reason. I understand all activities are tracked based on my user ID.

_____ I agree that I will hold Providence information in strict confidence and will not disclose or use it except (1) as authorized by Providence; (2) as permitted under written agreement between Providence and the Organization named
below or myself; (3) consistent with the reasons for my access; (4) solely for the benefit of Providence, its patients, its members, or its other customers; or (5) as required by applicable law.

_____I understand that e-mail is not a secure, confidential method of communication. I will not include confidential patient information in e-mail communications, unless using an approved secure email method.

_____I understand that should I need to use Providence network, email, or telephone; it is a privilege that may be revoked if I misuse these services. I also understand that these services may be monitored and audited by Providence.

_____I understand that should I need to work with Providence data outside of the systems to which I am granted access, I will use secure methods to dispose of files or documents containing PHI or other confidential information.

for Non-Providence Workforce Members (Attachment A)

_____I understand that if I breach the terms of this agreement, applicable Providence privacy and/or security policies, or applicable law (including without limitation the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH), Providence may terminate my access, and Providence will be entitled to all remedies it may have under written agreement or under applicable laws, as well as to seek and obtain injunctive and other equitable relief or contact law enforcement.

_____I will report all suspected privacy and security incidents immediately, but no more than 5 days from the date of discovery, to Providence's toll-free Breach Reporting Hotline number at 866-406-1290.

I acknowledge that I have read and understand the Providence Non-Employee Acceptable Use Agreement.

Signature: _____ Date: _____

Data Access Request Form
for Non-Providence Workforce Members

Fill in the information below to request Providence Network Access and EPIC.

PLEASE PRINT CLEARLY WHEN ANSWERING THE QUESTIONS BELOW:

First Name:	**MI:**	**Last Name:**
Job Title (Student Type):	**Email Address:**	
Street Address:		
City:	**State:**	**Zip Code:**
Phone Number:		
Have you had access to the Providence Computer Network in the past? *(circle your answer)* **Yes / No**		
If you had previous access, provide your login ID:		

In order to maintain user integrity and reduce duplication, the following identifiers are required for PSJH access:

Last 4-digits of your Social Security Number:	**Date of Birth:**

My Signature below indicates that the above information is true and correct.

Signature:	**Date Signed:**

Providence

Student/Faculty Clinical Passport

STUDENT _____ **PHONE** _____
SCHOOL _____ **EMAIL** _____
PROGRAM _____ **ROTATION DATE** _____

Disclaimer: By contract with your academic institution, all students and faculty participating in learning experiences at Providence St. Joseph Health must meet the following health and safety requirements. The academic institution is responsible for ensuring that requirements have been met prior to participation in the clinical experiences. Records will be kept at the academic institution and random reviews by Providence St. Joseph Health will occur on a regular basis. Documentation must always meet requirements at all times.

Tuberculin Status (Initial - Completed no more than 12 months prior to start of rotation)	**Check** _____

Tuberculosis testing; IGRA or Q-Gold blood test or two-step tuberculin skin test current within the last 12 months, and annual as per ministry requirements. If history of positive, please provide copies of chest x-ray results after positive TB test and medical clearance note from your provider.

MMR (Measles, Mumps, Rubella)	**Check** _____

Documentation of 2 MMR's at least four weeks apart after the age of one and/or positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed:

1. Written vaccination declination
2. Acceptance of vaccine

(Rubella vaccination is required in Alaska)

Varicella (Chicken pox)	**Check** _____

Documentation of 2 doses of varicella at least four weeks apart and/or positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed:

1. Written vaccination declination
2. Acceptance of vaccine

Hepatitis B (Hep B)	**Check** _____

Documentation of Hepatitis B vaccinations (series of 3 Engerix or Recombivax or 2 Heplisav) and positive laboratory titer. If laboratory titers are negative, one of the below actions must be completed:

1. Written vaccination declination
2. Acceptance of vaccine

(*Hep B vaccination is required in Alaska*)

Tetanus/Diphtheria/Pertussis	**Check** _____

Documentation of vaccination/booster or signed declination

Influenza (Annual)	**Check** _____

Documentation of vaccination or signed declination, including reason for declining.

BACKGROUND CHECKS – Must be current, completed no more than 1 year prior to start of rotation.	Check _____

- National Criminal Background Check and Washington State Patrol Background Check (WATCH) upon admission/re-admission and re-entry/hire to program to include all counties of residence & all Washington State counties per RCW43.43.830 and OIG and GSA screens. Excluded Provider search on:
    - 1. OIG http://exclusions.oig.hhs.gov/
    - 2. GSA http://www.sam.gov
- Washington State Patrol Background Check (WATCH annually thereafter), https://watch.wsp.wa.gov/
- Criminal History Disclosure (annual) and kept on file by education institution

COVID-19 Vaccination – All students are required to adhere to the same procedures as Caregivers and must also follow:	Check _____

Documentation of updated (most current) COVID-19 vaccine or a written declination for medical or religious purposes.

AHA/BLS Course (Course must be American Heart Association (AHA) BLS Provider	Date of Card Expiration _____

Card must be current and not expired. Renewal due every two years

Respirator Training	Check _____

Respiratory Protection (PAPR or N95 Fit Mask Testing), if required by setting or functions performed. If prior training is not for device provided by PH&S, PH&S will provide training/testing as appropriate.

INSURANCE – Professional Liability Policy	Date of Policy Expiration _____

Policy held by academic partner, as outlined in Clinical Education Agreement.

* Students who are granted exemptions or sign declinations may be subject to additional safety protocols including wearing a mask or other personal protective equipment, social distancing, and/or safety protocols at our discretion.
** Providence reserves the right to override any exemption request or declination and deny the student's clinical rotation experience for any or no reason at our discretion to maintain patient, faculty, and student safety.

ATTESTATION OF ACCURACY OF RECORDS

To be completed by an appointed representative of the Academic Partner

By my signature, I _____ (print name) certify that I have been informed of the immunization and vaccination requirements for students as outlined above.

I further certify that I have verified the accuracy and completeness of the student's immunization and vaccination records according to the above requirements, and that the information contained therein is accurate and complete to the best of my knowledge. I understand that I am responsible for maintaining, and procuring upon request, documentation of above information.

_____ _____

School Representative Signature Date

_____ _____

School Representative Printed Name Phone Number

_____

School Representative Email