New Hope Clinic, Inc.
EMPLOYEE/VOLUNTEER TRAINING CONTRACT

I, verify that on _(Date) _____New Hope Clinic Inc. provided me with training in the following areas: (Initial next to all training received)

_____HIPAA requirements and regulations
_____My rights and responsibilities under the OSHA Act
_____The hazards present in my workplace
_____The location and general content of my employer's OSHA policy and procedure manual
_____Hazardous Communications: location of the MSDSs and how to use them, chemical hazards and controls
_____Emergency Action Plan
_____Electrical safety, proper controls for x-ray (where appropriate)
_____Workplace violence: prevention, handling and response
_____Ergonomics: good body mechanics and engineering controls
_____Bloodborne Pathogen Exposure Plan
_____Infection Control Plan

Site-specific information was covered, and I was given an opportunity to ask questions.

I fully comprehend the material presented in this training session, and I understand that my failure to comply with New Hope Clinic policies may result in disciplinary action.

_____
(Employee's/Volunteer's Signature) (Date)

_____
(Printed Name)

FOR OFFICE USE ONLY

Volunteer Orientation – Version:_____ **Date:_____**

Safety Training & Clinic Tour – Version: _____

HIPAA & Documentation Issues – Version:_____

Quiz Name:_____ Version: _____ Score:_____

Bloodborne Pathogens & Infection Control – Version:_____

Quiz Name:_____ Version: _____ Score:_____

Access Database Updated: ☐Contact Info ☐Training Dates

Reviewed by: (Print/Sign)_____**Safety Coordinator: (**Print/Sign)_____

New Hope Clinic, Inc.
Confidentiality Agreement and Training Certification

Respecting the right to privacy is a basic element of New Hope Clinic's Management Policy. Information about a patient, volunteer, board member, donor or employee required in the conduct of the Clinic's business will be collected only by proper means, restricted to that which is relevant, used only for business purposes and maintained in a manner which will protect its confidentiality. All employees/volunteers are to review and acknowledge this policy annually.

Patient - I may view, have access to, or otherwise come across Protected Health Information ("PHI") (as defined in the HIPAA Privacy Rule) in the performance of my job for New Hope Clinic, Inc. (NHC). To ensure that all uses and disclosures of PHI that I am permitted or required to make in the performance of my job comply with the HIPAA Privacy Rule, I have read and understand the NHC policies regarding the privacy of individually identifiable health information, as mandated by the HIPAA Privacy Rule.

In addition, I acknowledge that I have received training in NHC policies concerning the permitted and required uses and disclosures of PHI. I understand and agree that I must use the electronic health records information software in a manner in compliance with the HIPAA Security Rule and NHC Policies and Procedures. I will be assigned a unique user identifier to permit access to the electronic health record. I am prohibited from releasing my sign-on or password to anyone else or allowing anyone else to access or alter information under my identity. I am required to lock or logoff the system when my workstation is unattended. Any suspected breaches of security and/or integrity of the system should be immediately reported to the Security Officer.

Employee/Volunteer/Board Members - The only information given without the express written consent of the employee/volunteer/board member or former employee/volunteer/board member regarding current or former employment or association will be verification of employment or association and relevant dates. No further information shall be released without the individual's written consent and the Executive Director's approval.

Donor - It is the policy of New Hope Clinic to respect and protect the wishes of our donors in regards to their confidentiality.

In consideration of my employment or association with NHC, I hereby agree that I will not at any time – either during my employment or association with NHC or after my employment or association ends – use, access, or disclose PHI or other confidential information to any person or entity, internally or externally, except as is required in the course of my duties and responsibilities with NHC, and as permitted by the NHC privacy policies and procedures. I understand that this obligation extends to any information that I may acquire during the course of my employment or association with NHC, whether in oral, written, or electronic form, and regardless of the manner in which access was obtained.

I understand and acknowledge my responsibility to apply New Hope Clinic, Inc. privacy and security policies and procedures during the course of my employment or association. I also understand that any unauthorized use or disclosure of information will result in disciplinary action, up to and including termination of my employment or association with New Hope Clinic, Inc.. I understand that my obligations (as set forth in this document) will survive the termination of my employment or the end of my association with New Hope Clinic, Inc., regardless of the reason for such termination.

Signed:_____ Printed Name:_____ Date:_____