Terrebonne
GENERAL HEALTH SYSTEM

t (985) 873-4141
e info@tghealthsystem.com

8166 Main Street
Houma, LA 70360
tghealthsystem.com

Dear Observer:

All applicants must have the following completed and returned to the Physician Relations Coordinator before being accepted into the Observation Program:

- Completed Sponsoring Physician Form. **It is the observer's responsibility to secure a sponsor, confirm all dates and requirements, and have the sponsor sign his/her form.**
- Signed Terrebonne General Health System Confidentiality Agreement
- Copy of photo ID
- Completed Attestation Sheet Form, as well as signed Declination Forms if applicable.
- After your complete application is received, it is required for you to obtain a temporary name badge from our Human Resources Department. Please contact the me at (985) 850-6314 to coordinate. **This badge must be worn at all times in the facility.**

If you have any questions, please do not hesitate to contact me.

Sincerely,

Sara Rodrigue

Sara Rodrigue
Physician Relations Coordinator
T: 985-850-6314
sara.rodrigue@tghealthsystem.com

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Observation Application

Personal Information **Date of Application:** _____

Name: _____ **Date of Birth:** _____

Address: _____

_____

City **State** **Zip**

Phone: _____ **Email:** _____

Emergency Contact: _____

Name **Relationship to Observer**

_____

Home/ Cell Phone **Work Phone**

Name of School Attending: _____

Level of Education/ Year into Program: _____

Requested Dates of Observation: _____

I certify that the statements made in this observation application are true and correct and have been given voluntarily. I understand that this information may be disclosed to any party with legal and proper interest, and I release the hospital from any liability whatsoever for supplying such information.

Signature of Observer: _____ **Date:** _____

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Sponsoring Provider Form

I, _____agree to sponsor _____, a Medical or Allied Health Student, and request that such person be admitted to the Terrebonne General Health System's Medical/ Allied Health Student Observation Program under my sponsorship.

Approved observation dates: _____

_____

_____

I accept the responsibility as the named Medical/ Allied Health Student's sponsor and agree to monitor such student's activities in the program and to advise each patient, prior to treatment, who is to be observed by the Medical/ Allied Health Student under my sponsorship of the Medical/ Allied Health Student's participation in the program, of his or her presence in procedures, and the Medical/ Allied Health Student's access to the patient's medical record. I further understand and agree that if any patient objects to the Medical/ Allied Health Student's access to such patient's records or presence or observation of any procedure(s), then the Medical/ Allied Health student shall not be allowed such access or to be present or observe such procedure(s).

_____ _____

Signature of Sponsoring Provider **Date**

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Confidentiality Agreement

I acknowledge that I, as a member of the Terrebonne General Health System team, have been granted access to TERREBONNE GENERAL HEALTH SYSTEM's Electronic Information System ("EIS") and/or TERREBONNE GENERAL HEALTH SYSTEM facilities which may contain protected health information (PHI) that is for use by me in the treatment of patients, for use in obtaining payment for healthcare services, or for other healthcare operation purposes as those terms are defined by the laws and regulations of HIPAA. I further acknowledge and understand that: a) EIS will provide me with access to protected health information ("PHI") and confidential and proprietary information about TERREBONNE GENERAL HEALTH SYSTEM and its relationships (the "Confidential Information"), which is confidential; b) that the disclosure of such Confidential Information is expressly prohibited to any person or entity inside or outside of TERREBONNE GENERAL HEALTH SYSTEM except for those people who are authorized by law or hospital policy to receive such information. I covenant and agree not to discuss this information with family or friends even if the information is about them and understand that my failure to maintain the confidentiality of such information is a violation of state and federal laws and hospital policies.
I pledge to protect all Confidential Information made available to me and pledge to follow hospital policies regarding such information. I understand that it is my ethical and legal responsibility to maintain and comply with all protection requirements.

Therefore I pledge to adhere to the following:

1. I will protect and maintain the confidentiality of all Confidential Information and PHI, regardless of whether it is oral, written or electronic. It will be disclosed only in accordance with the terms of this Agreement and the provisions of HIPAA Privacy and Security Laws and other federal and state statutes and regulations.
2. I will keep confidential all proprietary information with regards to TERREBONNE GENERAL HEALTH SYSTEM operations and financial activities and will not disclose this information to others without proper authorization.
3. I will not access or attempt to access PHI of patients except for direct treatment, payment or related operations. I will only access PHI of patients that I "need to know" about in order to complete my job. I shall not access PHI associated with fellow employees, friends, family or myself unless it is necessary to carry out my official duties and responsibilities.
4. I will not disclose my user name, password and/or pin to anyone. I will not use another person's user name, password and/or pin. I will lock or log off work stations when leaving them unattended.
5. I will securely store and protect any user names, passwords and/or pins that I am assigned so they are not available to other individuals.

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6. I will not use any of the Confidential Information or PHI for personal purposes or gain. I will not solicit patients for the benefit of another practice or entity. I understand that the EIS Software is licensed and copyrighted, shall not be shared with other software licensors, and must be kept confidential.
7. I understand that my access is monitored and I will be held responsible for all activity under my user access.
8. I will report breaches of confidentiality by others to the TERREBONNE GENERAL HEALTH SYSTEM Compliance Officer email at hotline@t.com
or by phone at 985-873-3121.
9. I understand that my user name is my electronic signature on the medical record, if applicable.
10. I agree not to alter parameter settings at computer terminals unless properly authorized in writing by TERREBONNE GENERAL HEALTH SYSTEM.
11. I pledge not to access any software to which I have been granted access unless I have been properly trained for such purpose.
12. I have reviewed and understand TERREBONNE GENERAL HEALTH SYSTEM policies associated with PHI and Security and agree to follow them without exception.
13. I understand that my failure to comply with any of the matters contained herein may result in: 1) loss of my access to EIS; 2) initiation and possible actions from state and/or federal investigations related to statutes and regulations governing the access and release of PHI, including but not limited to HIPAA; 3) initiation and possible actions from investigations of the Office of Civil Rights, U.S. Department of Health and Human Services as it relates to HIPAA; and 4) civil actions for breach of contract.

By my signature below, I acknowledge my understanding of all of the above and foregoing and I agree to be bound by the terms and commitments contained therein.

Printed Name of Observer	**Signature**	**Date**

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Immunization Attestation Form

Name of Observer:_____ Date:_____

Please complete the following grid. A check mark indicates compliance. Observer will maintain documentation for ALL items listed. This information must be available from the observer upon request.

Name of Observer	Proof of Negative TB test (within 12 months) or blood assay (T-spot).	MMR Vaccine, or Positive Titer, or Signed Declination Form	Tdap Vaccine or Signed Declination	Varicella Vaccine or Positive Titer: Varicella (Chicken Pox)	Hepatitis B Vaccine complete, or Positive Titer, or Signed Declination Form	Current Influenza Vaccination or Signed Declination Form	SARS-CoV- 2 Vaccine: Both Pfizer-BioTech or Moderna vaccines or single dose Johnson & Johnson's Jannsen or Signed Declination Form
Example Student	*YES*	*YES*	*YES*	*YES*	*YES*	*YES*	*YES*

I acknowledge and attest that I/we own, and have in our possession, the above documentation and reports. I also acknowledge and agree to regular compliance audits by Terrebonne General Health System to ensure documentation is available upon request. By the execution hereof, Observer hereby warrants and confirms to Terrebonne General Health System the accuracy of the information provided above.

Signature: _____