



RSD Confidentiality/Conduct Agreement
Kadlec Regional Medical Center ♦ 888 Swift Blvd. ♦ Richland, WA 99352
Education Department ♦ 942-2600

As a KRMC/RSD WBL Student, I agree that:

1. I shall hold as absolutely confidential all information that I may obtain directly or indirectly concerning patients, doctors or personnel, and not seek to obtain confidential information from patients or staff. Confidential information includes patient information and records, Medical Center financial and operating data, electronic mail, and other information of a private or sensitive nature. I understand that if I am found to have violated the hospital's policy on Confidentiality of Information, I will be subject to disciplinary action including legal action.
2. I understand that as a healthcare facility infection control is of primary importance to Kadlec Regional Medical Center. I will follow the hospital standards for infection control. If I am ill I will call and cancel my experience and arrange for one at another time. I will also follow proper hand washing procedures while in this facility.
3. My WBL experience is purely for the opportunity to explore occupations and jobs in the medical facility and without contemplation of compensation or future employment.
4. I shall be punctual and conscientious, conduct myself with dignity, courtesy and consideration of others, and endeavor to make my WBL experience professional in quality. I will wear the appropriate attire for my clinical setting.
5. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.
6. I shall attempt to resolve any problems related to my WBL experience with my supervisor designee, and, if unsuccessful, attempt to resolve any such problems with the Education Department WBL Coordinator.
7. I understand that KRMC/RSD reserves the right to terminate my WBL status as a result of:
 - (a) Failure to comply with hospital policies, rules and regulations.
 - (b) Unsatisfactory attitude, behavior, or appearance;
 - (c) Any other circumstances that, in the judgment of the department director, would make my WBL experience contrary to the best interests of the hospital.

By my signature, I certify that I have been informed of and understand my responsibility in maintaining the confidentiality of all patients, personnel, and hospital information. I have read and agree to be bound by the conditions contained in this agreement:

Student Signature

Date

In the event of injury or accident while at the learning site, the student will be taken to the Emergency department for assessment, evaluation and treatment as needed and the parent /legal guardian will be notified. Appropriate school staff will be notified no later then the next workday. The parent/legal guardian and/or student are responsible for any expenses incurred as a result of the Emergency Department visit.

Parent/Guardian Signature

Date

_____/WBL_____
Instructor/Class

Date

Print Student Name: _____

Phone: _____

Address: _____

School: _____

Emergency Contact: _____ Phone: _____

Emergency Health Information (special conditions, allergies or other medial or health concerns) :

Health Insurance: _____ Subscriber _____

Policy # _____ Subscriber # _____