Terrebonne
GENERAL HEALTH SYSTEM

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

8166 Main Street
Houma, LA 70360
tghealthsystem.com

Dear Medical/ Allied Health Student:

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
- Signed Acknowledgement of Receipt for the Medical, Allied or Mentoring Program Students Policy and Procedure handout
- Immunization records
  - Current TB or negative QuantiFERON-TB Gold and TB Questionnaire (enclosed)
  - MMR vaccines (2) or positive titer
  - Varicella vaccine (2) or positive titer
  - Hepatitis B vaccine (3) or positive titer
  - Tdap or Td vaccine
  - Influenza vaccination (during designated flu season Oct.-March)
- After your complete application and clearance from the Employee Health Office 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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# Medical/Allied Health 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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**TERREBONNE GENERAL HEALTH SYSTEM**
**TUBERCULOSIS QUESTIONNAIRE**
EMPLOYEE HEALTH DEPARTMENT

**Name:** _____Department Observing**:** _____

A positive Tb skin test indicates that you have a latent TB infection. A positive skin test means that sometime during your life you have come into contact with the tuberculosis bacteria. It DOES NOT mean that you have tuberculosis now.
In the past, a yearly Chest x-ray was thought to be a sufficient follow-up. However, some may develop an active tuberculosis
infection (relapse or re-infection) with a normal chest x-ray.
This brief questionnaire is a very important part of your annual screening and should be completed at least once a year. When you are finished, please return it to the Employee Health Office.

**Have you experienced any of the following: (If yes, explain in the space provided).**

**Productive, prolonged cough (2 weeks or more)** **[ ] NO [ ] YES _____**

**Chest pain** **[ ] NO [ ] YES _____**

**Coughing up blood** **[ ] NO [ ] YES_____**

**Fever** **[ ] NO [ ] YES_____**

**Chills** **[ ] NO [ ] YES_____**

**Night Sweats** **[ ] NO [ ] YES_____**

**Easily tired** **[ ] NO [ ] YES_____**

**Loss of appetite** **[ ] NO [ ] YES_____**

**Weight loss** **[ ] NO [ ] YES_____**

**Date of last physician visit: _____**

I am attesting that all of the above information is accurate. To the best of my knowledge, I am free of any pulmonary (lung)
symptoms or disease. If between now and my next annual Employee Health Screening, I should develop any of the above symptoms,

I agree to contact the Employee Health Nurse.

_____
**Signature**

_____ _
**Employee Health Nurse Signature Date**

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- If you are taking medication or have a disease (such as HIV positive, Malignancy, Steroid use, Chemotherapy, Organ Failure, Transplant, Greater than 10% under ideal body weight, Gastrectomy or Jejunoileal Bypass, Diabetes Mellitus) that may cause you to be immunosuppressed, please consult the Employee Health Nurse or the Infection Control Nurse.

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| | | |
|---|---|---|
| **Title: Observation by Medical, or Allied Health Students** | **Control No.: 8305-C** | **Version: 8** |
| **Replaces: v.7 Observation by Medical, or Allied Health Students** | | |
| **Policy Owner: Teresita McNabb (VP of Nursing) Administration** | | |
| **Reviewers: Sara Rodrigue (Physician Relations Coordinator)Ann Dupre (Medical Staff Manager), Josh Faucheux (Guest Services Manager), Kenneth Cortez (HR Manager), Mary Miller (VP of Physician Services)** | | |
| **Approvers: Mary Miller (VP of Physician Services), Teresita McNabb (VP of Nursing)** | **Date Approved: 01/15/2021** | **Date Last Reviewed: 01/15/2021** |

## Purpose:

N/A

## Policy:

It is the policy of Terrebonne General Health System to protect the confidentiality of all patients while providing an environment that allows Medical/Allied Health Students to further their educational endeavors by actively observing the practice of medicine and the operations of a full service acute care hospital under the supervision of a sponsoring physician or advanced practice clinician.

## Definition:

Anyone who is a member of one of the following categories and who is eligible for participation in this program by meeting the criteria set forth in this Policy with which the school does not have a contract with TERREBONNE GENERAL HEALTH SYSTEM for their degree program and by first having secured the sponsorship of a physician or advanced practice clinician who is in good standing of the TERREBONNE GENERAL HEALTH SYSTEM Medical Staff who has agreed to accept responsibility (the "Provider Sponsor") for such Medical/Allied Health Student's actions:

1. Students starting from a junior in high school through college interested in the healthcare profession.
2. A physician enrolled in an internship, residency, or fellowship program that is here for educational observation only and not seeking medical staff privileges.
3. An advanced practice clinician that is here for educational observation only and is not seeking advance practice professional membership or scope of practice.

## Procedure:

1. Medical/Allied Health Students, (see definition), shall be granted participation in this program for a specified limited time period only (the "Observation Period") and shall be

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registered with the Physician Relations Coordinator prior to making rounds, observing procedures, or accompanying providers within the facility.

2. Each Medical/Allied Health Student shall abide by and sign the Terrebonne General Health System Confidentiality Policy Statement as required of all Terrebonne General H employees.
3. The Physician Relations Coordinator shall retain the signed Confidentiality Policy of each Medical/Allied Health Student for a period of two years after expiration of the Observation Period.
4. The Provider Sponsor shall agree that, by sponsoring the Medical/Allied Health Student under this policy, he or she shall be responsible for all of the Medical/Allied Health Student's actions and for monitoring the Medical/Allied Health Student's activities while the Medical/Allied Health Student is a participant in the program (see attached form).
5. Medical/Allied Health Student observing procedures in any department shall follow the specific policy for that department in addition to this policy, (i.e, O.R., Cath Lab, etc)
6. Under no circumstances shall the Medical/Allied Health Student assist and/or perform medical care, procedures, give medical advice to the patients, or document in the patient record.
7. Each Medical/Allied Health Student shall be formally introduced to each patient prior to being allowed to observe the care and/or procedure to be observed. Patients wishing not to have the Medical/Allied Health Student present shall have their request honored. If the patient consents to allow the Medical/ Allied Health Student to observe the subject procedure, such consent to allow the observation must be documented in the medical record of such treatment, care or procedure.
8. Each Medical/Allied Health student shall provide a current immunization record or contact the Employee Health Nurse to arrange testing.
9. Each Medical/Allied Health student shall be issued an identification badge by the Human Resources Department, which shall be worn at all times while on the Hospital premises and shall be returned to the Physician Relations Coordinator at the end of such Medical/Allied Health Students last day of participation in the program.

## Equipment:

N/A

## References:

Form - Observation by Medical or Allied Health Students (Confidential Pledge)
Form - Observation by Medical or Allied Health Students (MD Sponsor)

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I hereby acknowledge the receipt of the following document:

Observation by Medical, Allied or Mentoring Program Students Policy and Procedure

_____ _____

Signature Date

Print Name: _____