

Instructions for Completing Career Orientation (Internship) Agreement

Step by step instructions for filling out the Career Orientation (Internship) Agreement Form are listed below for your convenience. If you have additional questions or need assistance, please do not hesitate to contact Nancy Weikel, Instructor, Student Services at (260) 373-7222, or email her at Nancy.Weikel@parkview.com. You may also contact Johnathan Liechty, Manager of Student Services, at (260) 373-7250, or email him at Johnathan.Liechty@parkview.com.

First Blank Line: Student/Individual's name

Second Blank Line: Student/Individual's address (Street, City, State, Zip)

Third Blank Line: Please include ALL of the following details:
Location desired (i.e. Parkview Hospital, Parkview Whitley, etc)
Unit/Department desired: (i.e. Pediatrics, Radiology, ER, etc.)
Start Date & End Date (i.e. 05/25/09 to 8/31/09)
Total Hours desired (i.e. 120 hours)

Fourth Blank Line: Date Requested

Fifth Blank Line: (Bottom of page, right side)
Signature of Student/Individual
Birth date of Student/Individual
Parent/Guardian signature (if applicable)

Completed forms should be mailed to:

**Parkview Student Services
Parkview Health
2200 Randallia Drive
Fort Wayne, IN 46805**

Completed forms may also be faxed to:

**(260) 373-3168
Attn: Student Services**

CAREER ORIENTATION AGREEMENT

BY AND BETWEEN

Parkview Hospital, Inc., Huntington Memorial Hospital, Inc. d/b/a Parkview Huntington Hospital, Whitley Memorial Hospital, Inc. d/b/a Parkview Whitley Hospital, Community Hospital of Noble County, Inc. d/b/a Parkview Noble Hospital, Community Hospital of LaGrange County, Inc. d/b/a Parkview LaGrange Hospital and The Orthopaedic Hospital at Parkview North LLC (collectively or individually "Facility")

AND

_____, whose address is _____,
(Individual).

WHEREAS, the Facility is organized for the purpose of operating a health care facility, including the operation of a _____ department, and,

In consideration of the mutual understanding that the student observation experience will be offered to allow the Individual to gain in-depth knowledge about a specific health career and that the experience will consist of observational experiences and limited, carefully selected "hands-on" experiences which the department deems appropriate.

Section 1. Relationship of Parties

Career Orientation Experience Individuals shall not be deemed to be employees or agents of Facility or of Parkview Health System, Inc. ("PHS").

Section 2. Responsibilities of the Individual

With respect to the Program identified in this Agreement, the Individual agrees that he/she:

- (i) has read and understands the accompanying information on Occupational Health and Safety Administration ("OSHA") Blood-Borne Pathogen Regulations, Hazardous Materials, Fire Safety/Codes, Infection Control and Infectious Waste;
- (ii) may be required to wear gloves, masks/face shields or other protective clothing;
- (iii) submits a signed "Confidentiality Agreement" to the Facility representative; agrees to dress in the appropriate manner for the professional environment (no jeans, shorts or sandals);
- (iv) will act in a professional manner in their observational role while at the Facility.

The Student will be solely responsible for expenses incurred during the career orientation educational experience regardless of whether such expenses are:

- (i) for health care services provided by Facility, or
- (ii) otherwise incurred in connection with the career orientation educational experience.

Section 3. Responsibilities of the Facility Representative

With respect to the Program identified in this Agreement, the Facility representative shall:

- (a) serve as a health care representative which Career Orientation Experience Student(s)/Individual(s) may be allowed to watch in selected roles, and assure that the experience is limited to only observation and/or department specified "hands-on" approved activities;
- (b) retain ultimate responsibility for patient care, ensuring that Facility staff direct or supervise all aspects of patient care.

Section 4. Term

It is understood and agreed that the term of this Agreement shall be from _____ to _____.

The parties have caused this Agreement to be executed and limited to the later day and year written below.

"FACILITY"

"STUDENT/INDIVIDUAL"

Parkview Hospital, Inc., Huntington Memorial Hospital, Inc. d/b/a Parkview Huntington Hospital, Whitley Memorial Hospital, Inc. d/b/a Parkview Whitley Hospital, Community Hospital of Noble County, Inc. d/b/a Parkview Noble Hospital, Community Hospital of LaGrange County, Inc. d/b/a Parkview LaGrange Hospital and The Orthopaedic Hospital at Parkview North LLC

BY: _____

BY: _____

Its: _____

Its: _____

Date: _____

Date: _____

Birthdate: _____ / _____ / _____

BY: _____
Parent's signature if student/individual is under age of 18.

CONFIDENTIALITY

What does it mean?

Confidentiality means “keeping information private.” In a hospital or healthcare setting, all patient information is considered confidential. Any information about patients that is spoken, on paper, or on computer is to be kept private. You cannot tell your family, friends, or anyone else (who is not taking care of the patient) about this information.

Examples of confidential information include:

- **Name**
- **Address**
- **Age**
- **Social Security Number**
- **Whether someone is in the hospital**
- **Diagnosis or reason why a person is in the hospital**
- **Treatments and medications**
- **Test results**
- **Past health conditions**

If you share any of these types of information with people who do not need to know, you have broken confidentiality
—and **you have broken the law!**

In addition to patient information, confidentiality must also include privacy of:

- **business-related information**
- **fellow employee personal and employment information**

PARKVIEW HEALTH
CONFIDENTIALITY AGREEMENT

I understand that in the performance of my duties as an employee, or Board member, a member of the Medical Staff or as an agent of Parkview Health (“PH”) or a PH affiliated entity (collectively “Parkview”), I am required and privileged to have access to and am involved in the processing of verbal, written, computer generated, computer accessed, filmed, and/or recorded information related to patients, physicians, employees and business information, all identified as “Confidential Information”, as defined by the Parkview Health Confidentiality Policy. I understand that I am obliged to protect and maintain the confidentiality of this Confidential Information at all times.

I acknowledge that if my position requires application of an electronic signature code, it is the equivalent of my legal handwritten signature. I understand that if I disregard the confidentiality of my electronic signature code, use the code of another person, or fail to comply with these confidentiality requirements, I will be committing an illegal and/or unprofessional act.

I understand that a violation of these confidentiality considerations may result in disciplinary action, up to and including termination from my position or legal action.

I certify by my signature that I have knowledge of the provisions of the Confidentiality Policy. I agree to adhere to and uphold Parkview Confidential Information.

Name: _____
(please print)

Signature: _____

Employee Number (if applicable): _____ Date: _____