AGREEMENT FOR PARTICIPATION IN SCHOLARLY ACTIVITIES AND
CONFIDENTIALITY AGREEMENT

1) The visitor/student/instructor/physician whose signature appears below wishes to participate in scholarly activities at Orlando Health and understands and agrees to the following conditions of such participation:
   a) I will conduct myself in an ethical and professional manner at all times during my visit at Orlando Health.
   b) I will comply with the Orlando Health dress code.
   c) I will adhere to and comply with the policies and procedures of Orlando Health.
   d) I understand that I am to report to and am directly responsible to my clinical instructor or assigned preceptor.

2) I understand that Orlando Health has the right to remove me from its facilities if my behavior is unsatisfactory, disruptive or detrimental to the facility.

3) I acknowledge and understand that I am subject to the risk of contracting disease or incurring bodily injury and/or property damage, as well as other risks that may not be foreseeable, as a result of participating in scholarly activities in ORLANDO HEALTH facilities. I hereby expressly assume any and all risk of illness, personal injury and/or death, and property damage. I further understand and acknowledge that ORLANDO HEALTH does not insure me against any illness, injury, or property damage that I might suffer as a result of participating in scholarly activities in ORLANDO HEALTH facilities. I understand that if I am injured or become ill while at ORLANDO HEALTH, In consideration of ORLANDO HEALTH making available to me the opportunity to participate in scholarly activities in ORLANDO HEALTH facilities, I hereby release, waive, discharge, and covenant not to sue ORLANDO HEALTH, its officers, directors, agents, employees, assigns, or successors, from any and all liability, claims, demands, actions, or causes of action arising out of any damage, loss or injury, to my person or my property resulting from or in any way connected to my participation in scholarly activities at ORLANDO HEALTH, whether caused by the negligence of ORLANDO HEALTH, its officers, directors, agents, employees, assigns or successors, or otherwise, except that which is the result of gross negligence and/or wanton misconduct of ORLANDO HEALTH.

4) I recognize and acknowledge that:
   a) In order to provide services to patients, providers, employees, and others, Orlando Health receives from and maintains confidential information about patients, providers, employees, and others.
   b) This confidential information includes individually identifiable health information ("Protected Health Information" or "PHI").
   c) Orlando Health is subject to federal and state laws and regulations regarding the confidentiality and security of PHI.
d) Orlando Health has enacted policies and procedures regarding the confidentiality and security of PHI and other confidential information

e) The good will of Orlando Health depends in part upon maintaining the confidentiality of confidential information, including PHI.

f) I acknowledge that while I am engaged in scholarly activities at Orlando Health, I may have access to confidential information, which may include PHI.

5) I agree that, except as directed by Orlando Health:

a) I will not at any time disclose any confidential information, including PHI, to any person or entity, except as required by law. In the event that I am required by law to disclose any confidential information, including PHI, I agree to immediately notify Orlando Health’s Student Coordinator, Education and Development Department of such requirement.

b) I will not at any time copy or permit any person to examine or make copies of any reports, files, charts, records, or other documents belonging to Orlando Health, including but not limited to PHI.

c) During the course of my practice experience, I may be required to discuss or write about private patient information. I agree that I will not discuss or write about private patient information outside of Orlando Health. I further agree that my practice experience related discussions and writings containing private patient information in Orlando Health will be in accordance with Orlando Health’s rules and policies.

d) If I discuss or write about my practice experience with an instructor, preceptor, classmate, or any other person for educational purposes outside of Orlando Health, I will keep the identity of all patients anonymous. This means that I will remove the following identifiers of patients or of relatives, employers, or household members of patients from any educational or academic writings or discussions I have outside of Orlando Health:

   (1) Names:
   (2) All geographic subdivisions smaller than a state, including street address, city county, precinct, ZIP code, and their equivalent geo codes, except for the initial three digits of a ZIP code if, according to the current publicly available data from the Bureau of the Census:
   (3) The geographic unit formed by combining all the codes with the same three initial digits contains more than 20,000 people; and
   (4) The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000.
   (5) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;
   (6) Telephone numbers;
   (7) Fax numbers;
   (8) Electronic mail addresses;
(9) Social Security numbers;
(10) Medical record number;
(11) Health plan beneficiary numbers;
(12) Account numbers;
(13) Certificate/license numbers;
(14) Vehicle identifiers and serial numbers, including license plate numbers;
(15) Device identifiers and serial numbers;
(16) Web Universal Resource Locators (URLs);
(17) Internet Protocol (IP) address numbers;
(18) Biometric identifiers, including finger and voice prints;
(19) Full face photographic images and any comparable images; and
(20) Any other unique or identifying number, characteristic, or code.

6) I also agree that I will not discuss or write about health information, even if stripped of the identifiers listed above, in a way that the information could be used alone or in combination with other information to identify an individual who is the subject of the information.

7) I understand and acknowledge that the disclosure of confidential information may cause irreparable injury to Orlando Health, patients, providers, employees, and/or others and that Orlando Health may take any action it deems necessary or advisable to prevent or mitigate such injury, including removing me from the premises, terminating any agreement with me or my school or program, and seeking legal remedies against me and/or my school or program.

8) I understand and acknowledge that I am not an employee of Orlando Health, that I am not entitled to any benefits accorded to Orlando Health employees (including but not limited to participation in employee benefit plans, workers’ compensation, and unemployment compensation) and that I will not be compensated by Orlando Health for my participation in scholarly activities.

9) I agree that this Agreement shall remain in effect during the time I am engaged in scholarly activities at Orlando Health, and after I have ceased scholarly activities at Orlando Health.

10) The provisions of this Agreement for Participation in Scholarly Activities and Confidentiality Agreement are in addition to any other conditions that apply to me pursuant to any affiliation agreement or other agreement regarding my participation in scholarly activities at Orlando Health.
CONSENT FOR PARTICIPATION IN SCHOLARLY ACTIVITIES AT ORLANDO HEALTH

I have read and understand the above orientation packet as well as the agreement for participation in scholarly activities and confidentiality and agree to abide by it at all times.

______________________________          ____/_____/______
Signature (Visitor/Student/Instructor/Physician)        Today’s Date      Date of Birth

______________________________
Print Name (Visitor/Student/Instructor/Physician)

______________________________
Signature of Parent/Guardian (if student is minor)          ____/_____/______
                          Today’s Date

______________________________
School

______________________________
Program/Major

Please return this completed and signed page to the student coordinator at:
Student Coordinator
1414 Kuhl Avenue, MP 14
Orlando, FL 32806