KAISER PERMANENTE
Staff Education & Development
Southern California

STUDENT PACKET SUBMISSION

Individual Student Preceptorship

Student Packets include the following COMPLETED forms:

Student Required Forms:

- ☐ Individual Student Orientation Verification Form (2 pages)
- ☐ Security Identification Badge Form
- ☐ EHS Student Health Screening Questionnaire
- ☐ Compliance/HIPAA Security Program Attestation Form
- ☐ HR Confidentiality Form
- ☐ HR Child Abuse Form
- ☐ HR Elder and Dependent Adult Abuse Reporting Requirements Form
- ☐ HR Drug-Free Workplace – Employee Acknowledgement Form (2 pages)
- ☐ HealthConnect Confidentiality and Non-Disclosure Agreement Form

Student Submit Copies Of:

- ☐ School (Malpractice) or Liability Insurance
- ☐ Background Check Authorization Release Form
- ☐ 10 Panel Drug Screening
- ☐ Flu Vaccination Verification Form - REQUIRED DURING FLU SEASON ONLY; NO EXCEPTIONS!
- ☐ Immunizations/Titers Records
- ☐ Licensure; if applicable (ex: RN License)
- ☐ Current BLS, ACLS, and PALS: if applicable (copy Front & Back)

KP Learn Training Completion Certificates: Website, Learn.Kp.org

http://kpnursing.org/ SCAL/professionaldevelopment/orientation/index.html

- ☐ 2019 SCAL New Employee: Safety & Environment of Care Training (Print Certificate)
- ☐ 2019 Prevention of Workplace Violence (Print Certificate)
- ☐ 2019 Hazardous Waste Training (Print Certificate)
- ☐ 2019 Ethics & Compliance Introduction: Building a Culture of Trust (Print Certificate)
- ☐ 2019 Infection Control & Patient Care Prevention Training (Print Certificate)
- ☐ Interacting with People with Disabilities (Print Certificate)
- ☐ SCAL Transgender Sensitivity Training (Print Certificate)

Please SEE STUDENT INSTRUCTIONS SHEET FOR KP LEARN MODULE UPDATES!

Faulty Requirements for Clinical Rotation/Preceptorship Approval

School Program Coordinator Required Forms:

- ☐ Complete & Submit – Clinical Rotation/Preceptorship Request Form
- ☐ Complete & Submit – NUID Request Form

**PLEASE NOTE: ONLY completed packets scanned and submitted electronically as a single PDF will be processed. Incomplete packets will be DELAYED or DENIED. All applications must be submitted (4 weeks) prior to ROTATION DATE. **

KAISER PERMANENTE
Staff Education & Development
Southern California

STUDENT PACKET INSTRUCTIONS

SCHOOL SUBMISSION: School Program Coordinator Responsibilities

- Clinical Rotation Request and the NUID forms must be submitted 30 days prior to student start dates.
- The school program coordinator or student must have a preceptor approval established prior to the clinical rotation request submission.
- KP Preceptor's facility/location and contact information must be provided on the clinical rotation request and NUID forms.
- The school will receive an approval notification via email from the Academic Liaison after forms are reviewed and in processing status.

Student Required Document Submission: Student Responsibilities

- All student packets must be submitted via email with the required online training course's completion certificate's within 2 weeks prior to the start date in a single PDF file to Eulonda Allen, Academic Liaison for Ambulatory Services at Eulonda.J.Allen@kp.org.

- Call to schedule final clearance at 626-851-5892

KP Learn Online Training Course Codes: Enter the Code in the Search Field

- 00804725 – 2019 Ethics and Compliance Introduction: Building a Culture of Trust
- 00804320 – SCAL 2019 Annual Safety & Environment of Care Training
- 00741255 – 2019 SSA University: Facility Infection Control and Patient Care Training.
- 00736908 – 2019 Prevention of Workplace Violence
- 00804314 – 2019 Hazardous Waste Training
- 00704694– Interacting with People with Disabilities
- 00755278 – Transgender Sensitivity Training-SCAL

Please note:

Incomplete clinical rotation request forms, NUID forms, and student submission packets will be immediately denied and start date will be delayed, if packets are not completed appropriately. The school program coordinator and student will be notified via email. **NO EXCEPTIONS!**

Thank you in advance.

Eulonda Allen, MBA
BP Academic Liaison for Ambulatory Services

KAISER PERMANENTE®
Medical Care Program
Southern California Region

HEALTH STATUS INFORMATION

According to the policy and procedures of Southern California Regional Human Resources (including HR 5.02) 22 CCR Section 7023, and CDC guidelines, all contracted medical center workers (e.g., registry and students) are required to demonstrate current immunity to the communicable diseases set forth in section 1.

1. Complete the following serology / immunization information:

Serologic immunity and/or up-to-date immunization is required. Enter date of titers and check box if immune or non-immune. If titer is negative or non-immune, MUST list immunization date(s). Give the last time immunized. The following number of doses are needed: 2 doses for rubeola, mumps, and varicella; 1 dose of rubella; and at least the first dose for Hepatitis B, or it can be declined in section 4. The first dose of MMR and/or varicella may be acceptable for clearance if the vaccine series was recently initiated (within last 30 days). The 2nd dose is mandatory per CDC schedule (28 days after 1st dose).

	Date of Titer	Immune	Non-Immune	Immunization Date(s)
Mumps				Dose #1: Dose #2:
Rubella				Dose #1:
Rubeola				Dose #1: Dose #2:
Varicella				Dose #1: Dose #2:
				Hx of disease: (circle one) Varicella or Shingles / Date diagnosed:
Hepatitis B				Dose #1: Dose #2: Dose #3:

Diagnosis of a history of chickenpox or shingles by a healthcare provider is acceptable for proof of varicella immunity.

2. Please answer the following questions by circling your response:

YES NO Have you had any new problem which **currently** is infectious or would prevent you from performing your assigned duties at this time? If "Yes", describe: _____

YES NO Have you had an unexplained weight loss in the last year? If "Yes", give amount lost: _____

YES NO Do you have a persistent cough (lasting 3 weeks or more)?

YES NO Do you cough up blood?

YES NO Do you have persistent, unexplained fevers or night sweats?

YES NO Do you have a rash? If "Yes", for how long? _____

YES NO Have you seen a doctor for any of the above? If "Yes", list which item(s) _____

3. Give the following tuberculosis screening information:

Provide date and result of 2 most recent TB skin tests or 1 IGRA (QFT or T-Spot). The last TST or IGRA needs to be within the last 12 months and "previous TST" needs to be within 2 years before starting work/rotation. A 2-step TST within a year is acceptable.

Last TST Date:	Result (mm of induration*)
Previous TST Date:	Result (mm of induration*)

Last IGRA Date:	Result:

IGRA result- indicate if positive or negative.

*Result should be in mm of induration for TST (i.e. "0" if no induration). If your TST/IGRA is newly positive, you will need to provide a report of a negative chest x-ray done after the TST/IGRA. If the TST/IGRA was previously positive, the results of a negative chest x-ray should be within 1 year of start date and on file at your registry/institution.

(If applicable): CXR Date:	Result:

4. Hepatitis B vaccine declination: I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection. I understand by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I have an occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series through my agency/institution. Sign if you want to decline the Hepatitis B vaccine. **Signature:** _____

5. Tdap Vaccine: Date of most recent vaccine or, if declining, circle Declination. **Date of Immunization:** _____ **or Declination.**

6. Seasonal Flu Vaccination: Date of Immunization: _____ *Students must receive current season's flu vaccination or may not rotate in the medical center.

I hereby affirm that the information provided in this questionnaire is accurate and fairly represents my current health status. I understand that any misrepresentation, misstatement or omission in this questionnaire, whether intentional or not, shall constitutes a breach of contract between contractor, or contract agency, and Kaiser Permanente. Any such misrepresentation, misstatement or omission, whether intentional or otherwise, may result in immediate suspension or termination of employment or contracted work by Kaiser Permanente. I understand my employer/agency will receive a copy of this completed form.

Signature: _____ **Date:** _____

Print Name: _____ Date of Birth: _____

Address: _____ Zip: _____ Phone: _____

Department where rotating: _____ Rotation dates: _____

Name of Institution/Agency: _____

☐ **Resident** ☐ **PA Student** ☐ **Medical Student** ☐ **Observer in Training** ☐ **Registry** ☐ **Nursing Student** ☐ **Traveler** ☐ **Sub-Contractors**
☐ **Vendors/Contractors/Suppliers**

KAISER PERMANENTE

FACULTY PREREQUISITE FORM

(Complete both pages and submit to KP Academic Liaison via email)

COURSE INFORMATION

Clinical Rotation Start Date: _____ Clinical Rotation End Date: _____ Hours per student: _____

Orientation Date: _____ School: _____ Student Level: _____

Course Title: _____ Unit/Dept.: _____

FACULTY INFORMATION

Faculty Name: _____ Faculty Cell #: _____ Faculty Office #: _____

Faculty/Designee Email: _____

Emergency Contact: _____ Relationship: _____ Telephone #: _____

Please complete the following:

1. Have you been a clinical instructor at Kaiser Permanente before? ☐ No ☐ Yes
2. Have you been a clinical instructor at the assigned/designated unit/department before? ☐ No ☐ Yes

REQUIRED DOCUMENTATION

1.	**Course Syllabus & Objectives**	**Provide Copy**
2.	**Professional License & Certification Verification** ☐ RN ☐ Other:	**Provide Copy** (if applicable) Exp. Date:
3.	**American Heart Association Certification (BLS – ACLS – PALS – NRP)**	**Provide Copy both sides** (if applicable) Exp. Date:
4.	**Criminal Record Search (Background Check)**	**Provide Copy** Date: _____
5.	**Drug Test** to include: amphetamines, benzoylecgonine, cannabinoids, opiates, phencyclidine, barbiturates, benzodiazepines, propoxyphene, methadone, oxycodone, and meperidine.	**Provide Copy** Date: _____

REQUIRED HEALTH SCREENING (PROVIDE DATES ONLY; NO DOCUMENTATION NEEDED) (NO DECLINATIONS ARE ACCEPTED)

Measles-Mumps-Rubella (MMR) Positive Titer or 2 Immunizations are **REQUIRED**	**Positive Titer Date:**	**Immunization #1 Date:**	**Immunization #2 Date:**		
Varicella Zoster Positive Titer or 2 Immunizations are **REQUIRED**	**Positive Titer Date:**	**Immunization #1 Date:**	**Immunization #2 Date:**		
Hepatitis B Immunity demonstrated by Titer or 3 immunizations is **REQUIRED** NO DECLINATIONS ARE ACCEPTED FOR ANY REASON	**Titer Date:**	**Positive?** Y or N	**Immunization #1 Date:**	**Immunization #2 Date:**	**Immunization #3 Date:**
Tuberculosis Screening (TB) Tuberculin Skin Test (TST) (12 & 24 months) or (2-step: baseline & retest 1-3 weeks) **or** Interferon-Gamma Release Assays (IGRA) Positive TB is **REQUIRED** to provide a negative CXR report	**TST** 12 & 24 months **Last 12 Months Date:** _____ **Result:** _____ mm **Last 24 Months Date:** _____ **Result:** _____ mm	or **TST** 2-step **Baseline Date:** _____ **Result:** _____ mm **Retest Date:** _____ **Result:** _____ mm	or **IGRA Date:**	**Negative Chest X-Ray Date:**	
Tdap NO DECLINATIONS ARE ACCEPTED FOR ANY REASON	**Immunization Date:**				
Influenza (Flu) Vaccination NO DECLINATIONS ARE ACCEPTED FOR ANY REASON	**Immunization Date:**				
Hepatitis A (Dietary Students only)	**Immunization Date:**				

KAISER PERMANENTE®

FACULTY PREREQUISITE FORM

HEALTH SCREENING QUESTIONS	
Do you have a condition that is currently infectious?	☐ No ☐ Yes, describe:
Have you had an unexplained weight loss in the last year?	☐ No ☐ Yes, amount lost:
Do you have a persistent cough lasting 3 weeks or more?	☐ No ☐ Yes
Do you cough up blood?	☐ No ☐ Yes
Do you have persistent, unexplained fevers or night sweats?	☐ No ☐ Yes
Do you have a rash?	☐ No ☐ Yes, for how long?
Have you seen a doctor for any of the above?	☐ No ☐ Yes, list which items:

REQUIRED READING (CONTENT AVAILABLE ON NURSING PATHWAYS WEBSITE)	
All Faculty (Clinical and Non-Clinical):	**Nursing Faculty Only:**
☐ Policies and Procedures: Student Unpaid Field Experience & Training SC.QRM.PCS.026	☐ Regional High-Alert Medication Safety Practices
☐ Appendix A: Onboarding Process	☐ KP Nursing Professional Practice Model
☐ Appendix B: Dress Code and Hygienic Practices	☐ KP Nursing Vision & Values
☐ Human Resources: Drug-Free Workplace NATL.HR.030	☐ Barcoding Scanning Medication Administration Instructions for Students
Compliance Principles of Responsibility: ☐ HIPPA 101: Privacy and Security Basics ☐ Prevent Fraud, Waste, and Abuse- Fact Sheet ☐ What is Protected Health Information	☐ **Inpatient only:** Nurse Knowledge Exchange Plus (NKE+)
☐ Ambulatory Health Care/Hospital National Patient Safety Goals	
☐ Situation, Background, Assessment & Recommendation (SBAR)	
☐ Emergency Codes	
☐ Medical Center Specific Requirements	

REQUIRED KAISER FORMS (READ, COMPLETE, SIGN & RETURN)	
Child Abuse Reporting Requirements (2860)	Compliance/HIPAA Security Program
Confidentiality Agreement (2870)	Drug Free Workplace- Employee Acknowledgement (2862)
Confidentiality & Non-Disclosure Agreement (HC)	Elder and Dependent Adult Abuse Reporting Requirements (2950)

OTHER MEDICAL CENTER REQUIRED DOCUMENTATION (FACULTY PLEASE CHECK THE BOXES TO INDICATE REVIEW AND COMPLETION)	
☐ KP HealthConnect Student-Instructor Access Data Spreadsheet/Common Provider Master (CPM) Form • Green colored headers completed • Submitted and sent to Medical Center's Academic Liaison/Designee	☐ Health & Safety Verification Form ☐ Medical Center Specific website items ☐ KP Learn website modules

OTHER ACKNOWLEDGEMENTS (FACULTY PLEASE CHECK THE BOXES TO INDICATE REVIEW AND UNDERSTANDING)	
☐ Food can be stored in designated areas. ABSOLUTELY NO FOOD OR DRINKS IN PATIENT CARE AREAS.	☐ Valuables should be left at home, lockers are not available.

I hereby affirm that the information provided is accurate and represents my understanding of the Prerequisite Requirements and my current health status. I understand that any misrepresentation, misstatement or omission during this process, whether intentional or not, shall constitute a breach of contract between myself and Kaiser Permanente and may result in immediate suspension or termination of program participation.

Faculty Name: _____ Faculty Signature: _____ Date: _____

KAISER PERMANENTE
Baldwin Park Medical Center
Employee Health Services
1011 Baldwin Park Boulevard, Baldwin Park, CA 91706
(626) 851-5266 Main (626) 851-5644 Fax (tie line 370)

Initial Screening Criteria for Students

1. TB Screening

a. **If History of Negative PPD**, documented proof of two PPD's are required, one dated within the last 2 years and one within the last 12 months. If neither is available, you will need a 2-step PPD.

b. **If History of Positive PPD (>10mm induration)**, *documentation of positive PPD is required or documentation of INH Therapy Course*. A written report of a PA and/or Lateral view of the chest within the last 12 months.

2. Hepatitis B Status

Any of the following:

a. Documentation of completed Hepatitis B Vaccine Series.

b. Proof of immunity demonstrated by hepatitis B antibody titer.

c. If a student is non-immune they may decline series (a signed Declination form is required).

3. Immunity to Childhood Diseases

a. Documentation of Lab titers positive for immunity to Rubella, Rubeola, Mumps and Varicella.

b. Vaccine record is acceptable as proof of immunity (two MMR and two Varicella).

c. Vaccination is mandatory if non-immune and no vaccine record.

4. Completion of the following:

a. Pre-Placement Health History Questionnaire and Assessment

The above information must be provided to us in order to complete your Employee Health screening. Employee Health is located in the basement of the Baldwin Park Medical Center. Our office hours are Monday through Friday from 8:00 A.M. to 5:00 P.M. If you have any questions, please do not hesitate to contact us.

Completed Health Clearance is Required Prior to being Scheduled to Work

Kaiser Permanente Health and Safety Verification Form

School Name: | Signature of faculty verifying this information is true: | Date:

Type of Student Program: | Course Title: | Rotation Dates:

Last Name (Including Instructor)	First Name (Including Instructor)	Emergency Contact Information	IGRA or Negative TST, 12 & 24 months or 2 step TST or Positive TST Date with Negative CXR Date		MMR Positive Titer or 2 Vaccinations			Varicella Positive Titer or 2 Vaccinations			Hepatitis B Positive Titer or 3 Vaccinations				Seasonal Flu	Tdap	AHA BLS Expiration	Criminal Record Search	Drug Testing	Food Service Programs Only Hep A Positive Titer or 2 Vaccinations, 6 months apart		
		Name/Relationship/Tel#	Date	Date	Titer Result Date	Date	Date	Titer Result Date	Date	Date	Titer Result Date	Date	Date	Date	Date	Date	Date	Date	Date	Titer Result Date	Date	Date

Revised 6/19/2018

KAISER PERMANENTE

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Compliance / HIPAA Security Program

Medical Center:_____

Instructions: Complete the fields below. **PRINT CLEARLY.**

Your Information		
LAST NAME	FIRST NAME	MIDDLE INITIAL
PRIMARY PHONE #		
PROGRAM:	SCHOOL:	
Instructor Information		
LAST NAME	FIRST NAME	PHONE #

Completion Attestation

I understand that required compliance training is an important part of Kaiser Permanente's compliance program.

My signature indicates that I, and no one on my behalf, has completed the **Annual Compliance Training.**

Principles of Responsibility Attestation

- I understand that the principles discussed in Kaiser Permanente's *Principles of Responsibility* apply to me.
- I have read, understood, and have familiarized myself with the *Principles of Responsibility*.
- I understand that I am expected to comply with Kaiser Permanente's security policies.
- If I have any questions about the *Principles of Responsibility*, I will seek clarification from the Academic Liaison.
- I understand that I am expected to conduct myself in an ethical and responsible manner at all times, in accordance with the *Principles of Responsibility*.
- In addition to complying with *the Principles of Responsibility*, I understand that I am also required to report any suspected compliance or ethics concerns I become aware of. I further understand that I am protected from retaliation for reporting any such concerns.

Privacy and Security Compliance Attestation

- I have a responsibility to protect the privacy and security of member/patient identifiable information (MPII) and protected health information (PHI).
- I must assess the risks to the privacy and security of MPII/PHI in my work environment and take steps to reduce those risks.
- I should seek assistance from my Regional Privacy and Security Officer or Compliance Officer if I have questions about what my job and the law allows me to do.
- I should report to my instructor/supervisor, Privacy and Security Officer, Compliance Officer or Compliance Hotline if I suspect that someone is not following the law or policy.

X

SIGNATURE **DATE COMPLETED**

KAISER PERMANENTE
HEALTHCONNECT

CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT

This CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT (the Agreement) is made between Kaiser Permanente (Kaiser Permanente) and the undersigned (you). This Agreement applies to your use of Kaiser Permanente's electronic medical record system, KP HealthConnect™, and related training materials to carry out your obligations and duties at your assigned Kaiser Permanente Medical Center. KP HealthConnect™ is a Kaiser Permanente trademark.

1. KP HealthConnect™ contains confidential information and proprietary materials owned by Kaiser Permanente and its licensors, such as Epic Systems Corp. The information and materials available in KP HealthConnect™ do not belong to you.

2. You must not print, transmit, download, transfer or make copies of any information, software or screen shots in this training.

3. You must protect the confidentiality of information in KP HealthConnect™ as required by State and Federal law.

4. You must use the KP HealthConnect™ user account assigned to you only if and when you need the information in KP HealthConnect™ to perform your work in the ordinary course of your assignment in providing services to Kaiser Permanente members and patients. You must not use KP HealthConnect™ user account for any personal or other purpose.

5. You must safeguard and keep your KP HealthConnect™ user ID and password secret. Sharing KP HealthConnect™ user ID and password with any other person, including co-workers or supervisors, is strictly prohibited. You must not use any other person's user ID and password to access any Kaiser Permanente system.

6. Kaiser Permanente may monitor your use of KP HealthConnect™ and your KP HealthConnect™ user account. You are personally accountable for any actions taken using the KP HealthConnect™ user ID issued to you.

7. You cannot share or exchange any confidential information with other personnel working at your hospital or facility unless it is required for you to perform your work. If any such sharing or exchange is required, you must follow the correct department procedure and the instructions of your supervisor/ chief of service (such as shredding confidential papers).

8. If you receive a request or demand from any person or organization other than Kaiser Permanente for confidential information or access to KP HealthConnect™, you must promptly notify your supervisor and Kaiser Permanente.

9. Your failure to comply with these obligations may result in the revocation of your KP HealthConnect™ user account and other actions by your employer or Kaiser Permanente.

10. On termination of your placement with Kaiser Permanente, you must return to Kaiser Permanente all copies of documents containing Kaiser Permanente's confidential information in your possession or control.

I UNDERSTAND AND AGREE TO COMPLY WITH THE TERMS STATED IN THIS CONFIDENTIALTY AND NON-DISCLOSURE AGREEMENT.

Print Name Sign Name Today's date

KAISER PERMANENTE

Welcome to Kaiser Permanente Southern California

Student Unpaid Field Experience and Training

Please read and complete the following required forms and submit to your Academic Liaison as instructed.

- Leave Employee ID and Work Phone Number sections blank
- Effective Date is the date you signed the form

- ☐ CHILD ABUSE REPORTING REQUIREMENTS (FORM 2860)
- ☐ CONFIDENTIALITY AGREEMENT (FORM 2870)
- ☐ CONFIDENTIALITY & NON-DISCLOSURE AGREEMENT (HC)
- ☐ COMPLIANCE / HIPAA SECURITY PROGRAM
- ☐ DRUG-FREE WORKPLACE-EMPLOYEE ACKNOWLEDGEMENT (FORM 2862)
- ☐ ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS (FORM 2950)

KAISER PERMANENTE®

2870 CONFIDENTIALITY AGREEMENT

The Effective Date represents the date the Confidentiality Agreement is signed.

* Employee ID	* Work Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* Employee First Name	Employee Middle Name	* Employee Last Name
* Job Title	* Location	

AGREEMENT

In my job, I may see or hear confidential information in any form (oral, written, or electronic) regarding:

- HEALTH PLAN MEMBERS AND PATIENTS AND/OR THEIR FAMILY MEMBERS (such as patient records, test results, conversations, financial information)
- EMPLOYEES, PHYSICIANS, VOLUNTEERS, CANDIDATES (such as employment records, corrective actions/disciplinary actions)
- BUSINESS INFORMATION (such as member rates, marketing plans, financial projections)

I will protect the confidentiality of this information. Access to this information is allowed only if I need to know it to do my job.

I AGREE THAT:

1. I will protect the privacy of our patients, members, and employees.
2. I will not misuse confidential information of patients, members, employees or Kaiser Permanente (including confidential business and personnel information) and I will only access information I have been instructed or authorized to access to do my job. With respect to Protected Health Information, I will only access or use such information as it is necessary to provide medical care to the member and/or patient or as necessary for billing and payment or health plan operations.
3. I will not access my family members' PHI. I will not access my own electronic medical records unless my job duties permit me to have access to electronic medical records (for example, KP HealthConnect). Instead, I will follow the same procedures that apply to non-employee health plan members.
4. I will not share, change, remove or destroy any confidential information unless it is part of my job to do so. If any of these tasks are part of my job, I will follow the correct department procedure or the instructions of my supervisor/chief of service (such as shredding confidential paper). If a demand is made upon me from outside Kaiser Permanente to disclose confidential information, I will obtain approval from my supervisor before disclosing such information.
5. I understand that inappropriate or unauthorized access, use or disclosure of PHI may result in legally required reporting to governmental authorities, including my name.
6. I know that confidential information I learn on the job does not belong to me and that Kaiser Permanente may take away my access to confidential information at any time.
7. If I have access to electronic equipment and/or records, I will keep my computer password secret and I will not share it with any unauthorized individual. I am responsible if I fail to protect my password or other means of accessing confidential information.
8. I will not use anyone else's password to access any Kaiser Permanente system unless I am authorized to do so. If I am authorized to do so (e.g., in order to perform computer systems maintenance), I will follow procedures to ensure the password is changed and that confidential information is not at risk.
9. I will lock my computer when I step away to prevent someone else accessing the computer under my logon. I understand that I am personally responsible for any accesses under my logon.
10. If I leave Kaiser Permanente I will not share any confidential information that I learned or had access to during my employment.
11. On termination of my employment, I will promptly return to Kaiser Permanente all originals and copies of documents containing Kaiser Permanente's information or data in my possession or control, unless the documents were provided to me as part of my employment record.

* First Name	Middle Name	* Last Name
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

AGREEMENT - (Continued)

Examples of Breaches of Confidentiality (What you should NOT do.)

These are examples only and do not include all possible breaches of confidentiality.

- Unauthorized reading of patient account information.
- Unauthorized reading of a patient's chart.
- Unauthorized access to my own medical information if my job duties do not permit me to have access to electronic medical records (for example, KP HealthConnect).
- Accessing medical information of friends, co-workers, family members, or anyone else, unless it is required for my job.
- Discussing confidential information in a public area such as a waiting room or elevator.
- Discussing or otherwise sharing confidential information with anyone in your personal life, including family members or friends.
- Accessing records for any reason other than for legitimate business purpose.
- Accessing records of family, friends, co-workers, patients in the media, well known political figures, celebrities, or anyone else about whom you are curious.
- Sending confidential information to your personal e-mail account, unless you are authorized to do so and the information is transmitted in accordance with required procedures (e.g., encrypted).
- Saving confidential electronic information to a KP-owned or non-KP-owned flash drive, CD, or any other removable or transportable storage device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Saving confidential electronic information to a KP-owned or non-KP-owned workstation, laptop computer, personal digital assistant, or any other mobile computing device unless you first secure permission as outlined in the Secure Electronic Storage provisions of the KP Information Security Policy.
- Using personal devices (digital cameras, camera phones) to take photographs that may include confidential information as the primary subject or in the background.
- Documenting or referencing confidential information on any social networking site, such as Twitter, My Space.
- Telling a co-worker your password so that he or she can login to your work.
- Telling an unauthorized person the access codes for employee files or patient accounts.
- Being away from your workstation while you are logged into an application, without locking your system to protect confidential information.
- Unauthorized use of a co-worker's password to logon to a Kaiser Permanente information system.
- Unauthorized use of a user ID to access employee files or patient accounts.
- Allowing a co-worker to use your secured application* for which he/she does not have access after you have logged in.

* secured application = any computer program that allows access to confidential information. A secured application usually requires a user name and password to log in.

KAISER PERMANENTE

2870

CONFIDENTIALITY AGREEMENT

* First Name	Middle Name	* Last Name
* Employee ID	* Work Phone Number (###)###-####	* Effective Date (mm/dd/yyyy)

AGREEMENT - (Continued)

12. I understand that I am responsible for my access, use, or misuse of confidential information and know that my access to confidential information may be audited.
13. I understand that my supervisor/chief of service or other managers and/or the Compliance Hot Line are available if I think someone is misusing confidential information or is misusing my password. I further understand that Kaiser Permanente will not tolerate any retaliation because I make such a report.
14. I understand that patient privacy and security is included in various training programs within Kaiser Permanente (for example: New Employee training, Annual Compliance Training), and by taking such training, I understand the obligations of confidentiality. I further understand that it is my responsibility to secure guidance from my supervisor or manager in the event any questions exist relating to my obligations regarding confidentiality.
15. I understand that this policy is not meant to prohibit any protected rights provided for in the National Labor Relations Act (for represented employees).
16. I understand that failure to comply with this agreement may result in disciplinary action up to and including termination of employment or other relationship with Kaiser Permanente. I understand that I may also be subject to other remedies allowed by law.
17. I understand that I must also comply with any laws, regulations, and other Kaiser Permanente policies, including the Principles of Responsibility that address confidentiality.
18. By signing (or selecting the submit button below), I agree that I have read, understand, and that I will comply with this Confidentiality Agreement.

SIGNATURE (Required if not submitted online)

* Employee Signature

* Date (mm/dd/yyyy)

KAISER PERMANENTE®

2860

CHILD ABUSE REPORTING REQUIREMENTS

Instructions: 1.To ensure efficient and effective service please, submit form online.
2. Items marked with an asterisk (*) are required fields.
3. Remember to print copy of form before submitting.
4. Immediate confirmation will be sent to you upon receipt of your online submittal.

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)

* First Name	Middle Name	* Last Name

1. REQUIREMENTS

Section 11166 of the Penal Code requires any child care custodian, health practitioner, or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment who he or she knows or reasonably suspects has been the victim of child abuse or who he or she knows or reasonably suspects that a child is suffering serious emotional damage or is at substantial risk of suffering serious emotional damage to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.

The identity of all persons who report shall be confidential and disclosed among agencies receiving or investigating mandated reports, to the district attorney in a criminal prosecution, or in an action initiated under Section 602 of the Welfare and Institutions Code arising from alleged child abuse, or to counsel appointed pursuant to subdivision (c) of Section 317 of the Welfare and Institutions Code, or to the county counsel or district attorney in a proceeding under Part 4 (commencing with Section 7800) of Division 12 of the Family Code or Section 300 of the Welfare and Institutions Code, or to a licensing agency when abuse or neglect in out-of-home care is reasonably suspected, or when those persons waive confidentiality, or by court order.

"Health practitioner" includes physicians and surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, or any other person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code; marriage, family and child counselors, emergency medical technicians I or II, paramedics, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code; psychological assistants registered pursuant to Section 2913 of the Business and Professions Code, marriage, family and child counselor trainees as defined in subdivision (c) of Section 4980.44 of the Business and Professions Code; state or county public health employees who treat minors for venereal disease or any other condition; coroners; paramedics; and religious practitioners who diagnose, examine, or treat children.

Volunteers whose duties include direct contact with and supervision of children are not mandated reporters, but are encouraged to report instances of child abuse and neglect.

Your department chief or supervisor should be notified whenever you believe you may be required to report suspected child abuse.

I understand and agree, if in a "Child Care Custodian" or "Health Practitioner" classification, as defined above, to comply fully with the above-cited provisions of the California Penal Code, in accord with procedures established by my Employer/Medical Center.

2. EMPLOYEE SIGNATURE

Signature - (Required if not submitted online).

* Employee Signature	* Date (mm/dd/yyyy)

Facility / Department

2860 11/21/2006 11

National HR Service Center
Telephone: (877) 457-4772

KAISER PERMANENTE®

2862 DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

Instructions: 1. To ensure efficient and effective service, submit form online. Immediate confirmation will be sent to you upon receipt of your online submittal.
2. If online submittal is not feasible, fax your form to National HR Service Center (877) 477-2329 or interoffice mail to HR Service Center, Alameda.
3. Remember to print copy of form before submitting.
4. The Effective Date represents the date the Drug-Free Workplace Employee Acknowledgement is signed.

* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)
* First Name	Middle Name	* Last Name

1. EMPLOYEE INFORMATION

* Work Phone Number - Tieline (###) ###-####	* Work Phone Number - Outside (###) ###-####	NUID # (if known)
Location/Facility Name	Department	

2. ACKNOWLEDGEMENT

I understand that, as a provider of health care, Kaiser Permanente recognizes that alcohol and drug abuse/chemical dependency is a chronic disease and major health problem that can have tragic consequences for individuals, families, and the workplace.

As a condition of employment, all employees are expected to abide by the organization's policy which prohibits the use and/or abuse of drugs and alcohol in the workplace.

By my signature below, I acknowledge, understand, accept, and agree to comply with this policy. I also understand that failure to comply with this policy will result in corrective/disciplinary action, up to and including termination of employment.

DRUG-FREE WORKPLACE ATTESTATION

- I have received a copy of the policy NATL.HR.030, Drug-Free Workplace.
- I have read, understood, and familiarized myself with this policy, and understand that Kaiser Permanente is committed to providing a drug-free workplace.
- I understand that it is my responsibility to comply with this policy, and that this policy applies to me.
- I agree to abide by the terms of the policy, as a condition of employment.
- I understand that violations of this policy will subject me to corrective/disciplinary action, up to and including termination of employment.
- If I have any questions about this policy, I will seek clarification from my manager or a KP HR Representative.
- I understand that, in acknowledgment that chemical dependency is a chronic disease and that rehabilitative treatment is available, KP supports and strongly encourages employees with such problems to seek treatment, and will provide it when conditions and circumstances warrant.
- I understand that the responsibility for seeking, obtaining, and cooperating in such treatment is mine.
- I understand that, if I am experiencing alcohol or drug dependency, I am urged by the organization to make use of KP's confidential Employee Assistance Program, and/or such disability plans, rehabilitation programs, and health coverage plans that may be appropriate.

3. EMPLOYEE SIGNATURE (Required if not submitted online)

* Employee Signature	* Date (mm-dd-yyyy)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

KAISER PERMANENTE®

2862 DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT

* First Name	Middle Name	* Last Name
* Employee ID	* Contact Phone Number (###) ###-####	* Effective Date (mm/dd/yyyy)

After completing the form:
1. Print form to keep a copy for your records.
2. Print another copy and sign it for your supervisor.
3. Press the Submit button.
4. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)
5. Submit online or fax your form to the National HR Service Center (877) 477-2329 or
   interoffice mail to National HR Service Center, Alameda.

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772
Executives: Contact your Executive Benefits Specialist

KAISER PERMANENTE®

2950 ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

* Employee ID	* Home Phone (###) ###-####	* Work Phone (###) ###-####	* Effective Date (mm/dd/yyyy)

* First Name	Middle Name	* Last Name

1. ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

California Welfare and Institutions (W&I) Code Section 15659 requires Kaiser Permanente Medical Program to provide all "health professionals" and "care custodians" information concerning their responsibility to report incidents of observed, known, or suspected elder and dependent abuse. All health practitioners or care custodians must sign a statement acknowledging receipt and understand of the **mandatory** elder and dependent abuse reporting requirements. Kaiser Permanente must retain the signed statement.

Elders are persons 65 years of age or older. **Dependent adults** are persons between the ages of 18 and 64 with physical or mental limitations such as physical or developmental disabilities or age-diminished physical or mental abilities. The law also expressly includes any person between the ages of 18 and 64 who is admitted as an inpatient to an acute care hospital or other 24-hour facility as a dependent adult. (W&I Code Sections 15610.23, 15610.27 and 15701.2)

Abuse of and elder or dependent adult means either of the following:
(a) Physical abuse, including lewd or lascivious acts, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering; or
(b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering. (W&I Code Section 15610.07)

At Kaiser Permanente, a physician, nurse, and licensed or unlicensed health care professional, including administrative and support staff, who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of elder and/or dependent abuse, or reasonably suspects elder and/or dependent abuse, **shall report by telephone immediately or as soon as practically possible and by written report within two (2) working days** as follows:
(a) to the long-term care ombudsmen or the local law enforcement agency when the abuse is alleged to have occurred in a long-term care facility;
(b) to the State Department of Mental Health, the State Department of Developmental Services, or the local law enforcement agency if the abuse is alleged to have occurred in a state mental health hospital or state developmental center; or,
(c) to the adult protective services agency or the local law enforcement agency when the abuse is alleged to have occurred anywhere else. (W&I Code Section 15630)
All incidents should be documented and forwarded to the appropriate agency in accordance with local medical center procedures.

I certify that I have read and understand this statement and will comply with the requirements of the Elder and Dependent Abuse Reporting Law.

2. SIGNATURE

* Employee Signature	* Date (mm-dd-yyyy)

Facility / Department

National HR Service Center
Telephone: (877) 457-4772