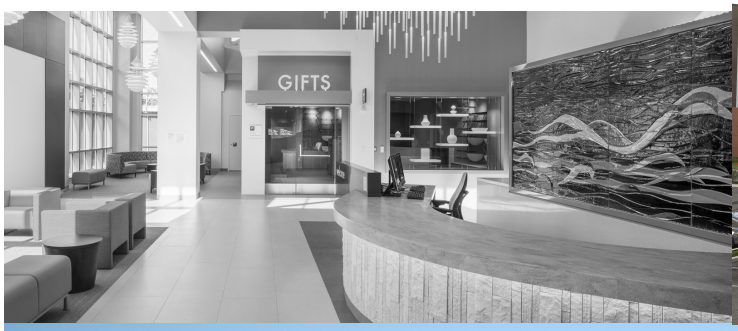
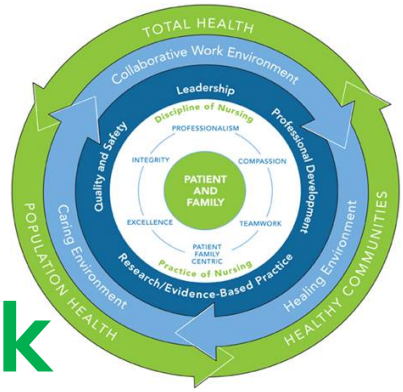
KAISER PERMANENTE® thrive



South Bay Medical Center

School Affiliates

Orientation Handbook



Developed by **Nursing Education & Professional Development**

Table of Contents

Created by M. Rozario, MSN, RN, PHN – Nurse Administrator Intern 12/2017
Updated 2/2018

Welcome to Kaiser Permanente South Bay Medical Center!

Thank you for taking the time to explore the educational opportunities available to you at our medical center and ambulatory medical office buildings which make up the South Bay Medical Center.

Kaiser Permanente has been a long-standing pillar in providing sensitive, compassionate and competent care for the South Bay community. Here at South Bay, we understand the profound contribution healthcare providers make to our success. Our staff direct impact every patient outcome and they are integral to the success of our organization.

Through our strong unit-based team structure, our staff continually strive for excellence and optimal outcomes for our patients. We practice shared governance to create evidence-based changes that continuously improve care.

Our Nursing Education and Professional Development Department has provided an opportunity for healthcare students from our community to further develop their skills and provide an exceptional educational experience through clinical placements in various departments across the South Bay Medical Center.

This booklet will serve as a resource that will help your educational institution determine what our medical center has to offer and what we expect from all our staff.

Karen M. Sielbeck **MSN, RN**
Chief Nurse Executive
Kaiser Permanente South Bay Medical Center

Teresa H. Siaca **MS, RN, CNML**
Assistant Medical Group Administrator
Kaiser Permanente South Bay Medical Group

The South Bay

Acute Care Hospital Services

Medical Surgical Telemetry
Labor & Delivery
Postpartum
Antepartum
Neonatal Intensive Care Unit
Surgery
Intensive Care Unit
Direct Observation Unit
Respiratory Therapy
Diagnostic Imaging
Emergency

KAISER PERMANENTE serves more than 240,000 members in the South Bay

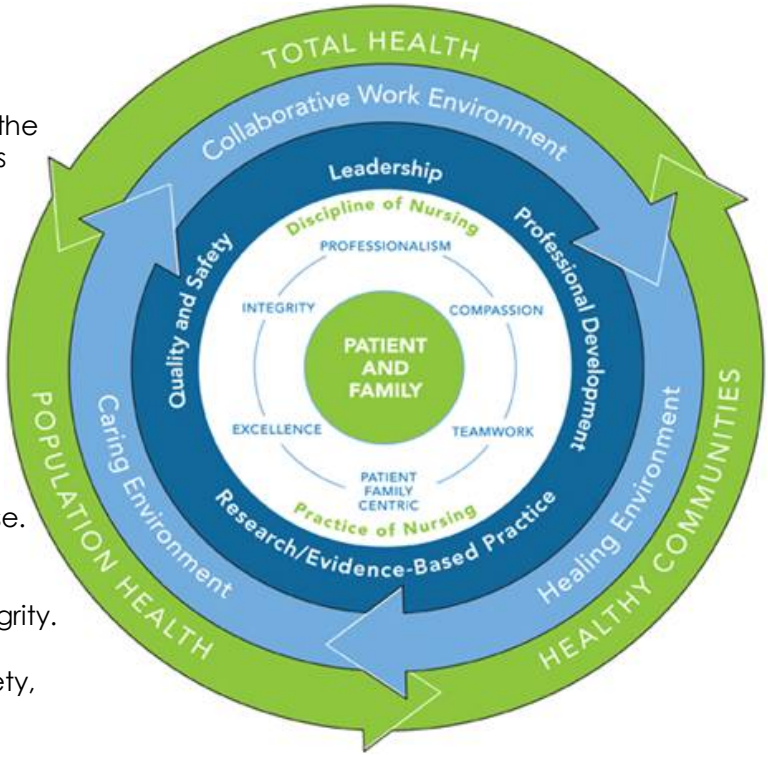
Outpatient Services

Primary Care
Obstetrics & Gynecology
Pediatrics
Physical/Occupational Therapy
Addiction Medicine/Chemical Dependency
Oncology
Urology
Endocrinology
Plastic Surgery
Ophthalmology
Orthopedics
Surgical
Urgent Care
Long-Term Care
Home Health/Hospice
Dermatology

The Voice of Nursing

At the heart of the Kaiser Permanente Nursing Professional Practice Model is the patient and family. The nurse-patient/family relationship is the cornerstone of nursing practice and leverages the powerful role human relationships play in creating caring and healing environments. It honors the unity of the whole human being – mind, body, spirit – and is the lens through which Kaiser Permanente nurses look to ensure that they meet the needs of the patient and families.

Six nursing values are embedded in our discipline/practice and help to demonstrate what it means to be a Kaiser Permanente nurse. The values that underpin our work are: Professionalism, Patient and Family Centric, Compassion, Teamwork, Excellence, and Integrity. Our practice and the work of nursing are organized by four key pillars: Quality and Safety, Leadership, Professional Development, and Research/Evidence-Based Practice.



Kaiser Permanente nurses advance the art and science of nursing in a patient-centered healing environment through our professional practice model.

Extraordinary nursing care. Every patient. Every time.

Our Strategic Anchors

Clinical Quality

Provide high-quality culturally sensitive, best in nation care

Meet or exceed the maximum regional target for clinical quality indicators across the continuum of care

CONVENIENT & Easy Access

Transform our care delivery such that our members can access care when and where they want

Achieve access targets in all clinical care settings by providing flexible options and adequate supply to meet demand

Caring with a PERSONAL TOUCH

With a patient-centered approach to care, anticipate and exceed expectations

Achieve 90th percentile in overall rate hospital and meet target for or exceed maximum regional targets across continuum of care

CARE that is AFFORDABLE

Be the market leader in value for healthcare in the company

Consistently achieve our combined margin target and combined expense budget PMPM

CREATING TOTAL HEALTH in our COMMUNITIES

We are actively engaged in spreading total health in our community

Understand and embrace the cultivate strategy as a business imperative

WORKFORCE ENGAGEMENT

Create a high-performance culture to foster a healthy and empowered workforce

Maintain a patient-centered workforce through Just Culture with noble purpose, accountability, and safety

Thrive at South Bay

Kaiser Permanente is the nation's largest not-for-profit integrated health care delivery system. While our tagline embodies the company's commitment to its brand promise of total Health, thrive is far more than a tag line; It's about a brand strategy supported by a well-entrenched mission and a commitment to a model of care that is centered on members and patients.

Our brand is the entire experience that our members, patients, customers and the public have with us. This includes what we present, what we influence and what our stakeholders experience with us—meaning the actual quality and services rendered. Our people work every day to ensure that our brand platform, known as total Health, is extended beyond advertising to direct marketing, business marketing, internet services, internal communications, public relations, social media and issues management. Here's how we do it at South Bay:

FARMERS MARKET

Every Wednesday from 9am to 2pm

EVERYBODY WALKS!

Walking paths around the facility.

Academic Liaison

Debra A. Barrath, MN
Director of Nursing Education & Professional Development

Ellainne Valderrama, MPH, CHES
Assistant Department Administrator

David Largo
Associate Project Analyst, Ambulatory
Tel: (424) 251-7690

Michelle L. Pascascio, BSN, RN
Inpatient Nurse Educator, Maternal Child Health

Christina Coreas
Associate Project Analyst, Inpatient
Tel: (424) 251-7686

For all inquiries, please contact us at:

SB-Students@kp.org

The Application Process

School Contract

Kaiser Permanente Southern California School Affiliation Contract Agreement

A current **KAISER PERMANENTE SOUTHERN CALIFORNIA (KPSC) REGIONAL SCHOOL AFFILIATION CONTRACT AGREEMENT** with Kaiser Permanente is required for all placements.

If you do not have a current contract with KPSC, please contact our department to inquire about the application and requirements at:

- SB-Students@kp.org

Student Placement

Identifying student placement opportunities

IT IS HIGHLY RECOMMENDED TO CONTACT OUR NURSING EDUCATION DEPARTMENT FOR PLACEMENT FOUR MONTHS BEFORE PLANNED START DATE

Once an established contract is confirmed, please complete a ***ROTATION/PRECEPTORSHIP APPLICATION*** form *(See Appendix A & B)* and include the following:

1. Course Syllabus & Objectives
2. Time frame of placement & number of hours
3. Identify department/area that meets course objectives

Application Process

Beginning the application process for student placement

Kaiser Permanente Nursing Pathways Website

To access the student placement application, go to the Nursing Pathways website:
http://kpnursing.org/_SCAL/professionaldevelopment/orientation/index.html

In the **Medical Center-Specific Information** section, select **South Bay** under Ambulatory or Inpatient.

Access to KPHC & KP Learn

Access to **KAISER PERMANENTE HEALTHCONNECT (KPHC)** is necessary for documentation of patient information, encounters, and services provided. KPHC is essential for clinical placements that involve direct patient care. Access to **KAISER PERMANENTE LEARN (KPLEARN)** is required for all students in order to complete the online learning modules as part of the onboarding process.

<table>
<tr><th colspan="2">GAINING ACCESS TO KP HEALTHCONNECT & KP LEARN</th></tr>
<tr><td>For Inpatient Placements send to:
Deanna Suarez, Nursing Staffing Office
Deanna.R.Suarez@kp.org</td><td rowspan="2">DEADLINE:

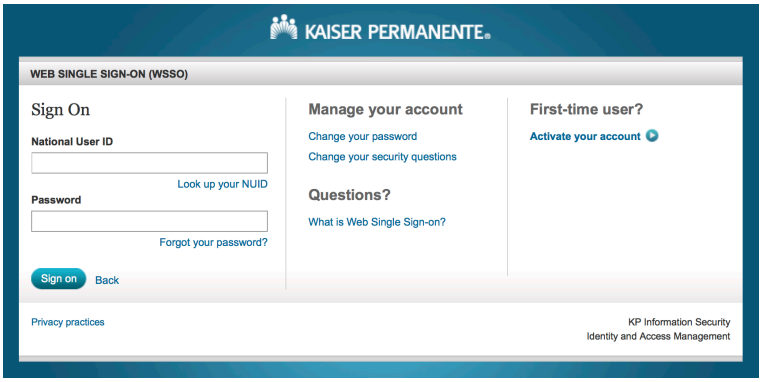
1 Month before start date</td></tr>
<tr><td>For Ambulatory Placements send to:
Nursing Education & Professional Development
Attn: David Largo

SB-Students@kp.org</td></tr>
<tr><td colspan="2">Submit the Common Provider Master (CPM) form (See Appendix O) to gain access to KP HealthConnect and KP Learn.</td></tr>
</table>

National Users Identification (NUID) Number

- An NUID is a unique identifier assigned to individuals
- All students and instructors will be issued an NUID
- An NUID contains 1 letter followed by 6 numbers (ex: A123456)
- The student /instructor will continue to use their specific NUID if ever employed by Kaiser Permanente – **NOTIFY THE DEPARTMENT, IF ALREADY A KP EMPLOYEE**
- An NUID is required for:
    1. Access to KP Learn modules
    2. Access to KP HEALTHCONNECT (Electronic Medical Record)
    3. Glucometer testing

Activate your NUID and create a password by going to:
https://extsso.kp.org/kpsso/signIn.html



Required KPLearn Modules

- To access KPLearn, go to: https://kplearn.kp.org
- Log on with your NUID and password.
- To search for the KPLearn module, go to the SEARCH box and enter the title of the module.

REQUIRED INPATIENT MODULES

KP Learn Module Course		Time
1.	Ethics and Compliance Introduction: Building a Culture of Trust (current year)	1 hr
2.	Safety Training: CA – Hospital/MOB – Initial/Comprehensive – OSHA/Safety	45 min
3.	Prevention of Workplace Violence	1 hr
4.	Safe Patient Handling (Hospital Initial Assignment CA only - current year)	1 hr
5.	Interacting with people with disabilities	30 min
6.	Mobility and Ambulation – SCAL	30 min
7.	High Alert Medication Program (HAMP) Independent double check workflow (current year)	10 min
8.	Pain assessment and management – SCAL	45 min

REQUIRED AMBULATORY MODULES

KP Learn Module Course		Time
1.	Ethics and Compliance Introduction: Building a Culture of Trust (current year)	1 hr
2.	Safety Training: CA – Hospital/MOB – Initial/Comprehensive – OSHA/Safety	45 min
3.	Prevention of Workplace Violence	1 hr
4.	Interacting with people with disabilities	30 in

Print and submit ***Certificates of Completion*** in the student packet.

KP HealthConnect (KPHC)

If students and faculty will be providing direct patient care, they will be required to complete mandatory training for KPHC.

KAISER PERMANENTE HEALTHCONNECT | Epic

- **Ambulatory Placements (Nurse Practitioner Students only)**
  Once NUID access is granted, the student will contact the Department Administrator (DA) of the clinic to which the student is assigned to complete hours. The DA will be responsible for scheduling live, on-campus KPHC training for NP Students. Training will be typically 3-days in length.

- **Inpatient Placements (Nursing Students only)**
  Once NUID access is granted, students and faculty will need to complete the following KPLearn module below. A certificate of completion for the module must be printed and included in the student packet.

KP Learn Module Course		Time
1.	KP HealthConnect Inpatient Training for Nursing Students Class ID: ***00765490***	4 hrs

****Note: Class ID numbers may change each year****

In an effort to keep our members and the community safe, all individuals must comply with DHS regulations

Employee Health

EMPLOYEE HEALTH CLEARANCE	
Send to: **Employee Health Department** EmployeeHealth-SouthBay@kp.org cc: SB-Students@kp.org	**DEADLINE:** **1 Month before start date**
Submit the **Health Questionnaire Paperwork** & required supplemental documentation *(See Appendix E & F)*.	

Employee Health Requirements

Students and instructors must have current records for the following requirements:

TB

Negative TB Test
- TST and/or IGRA
- Proof of 2 negative results
  1 within the last **24** months and 1 within the last **12** months

Positive TB Test
- Requires written report of negative chest x-ray within 1 year of start date of current academic program
- Must complete "Interval Health Evaluation Questionnaire" form *(See Appendix F)*

MMR

- Positive titer - or - 2 vaccination dates
- Vaccination is *mandatory* if non-immune and no vaccine record

Varicella

- Positive titer - or - 2 vaccination dates
- Vaccination is *mandatory* if non-immune and no vaccine record

Hepatitis A (Food & Nutrition students only)

- Hepatitis A Antibody titer - or - Documentation of 2 vaccinations, 6 months apart

Hepatitis B

- Hep B surface antibody titer required
- If titer negative, then must have 3 vaccination dates

Seasonal Flu Vaccination

- Proof of flu vaccination during current flu season must be presented prior to the start of the student placement
- Declinations are NOT accepted. Students who decline the seasonal flu vaccine will NOT be able to complete a student placement at South Bay Medical Center.

Tdap

- Date of vaccination required
- Vaccination must be within the last 10 years
- Declination form available, but highly discouraged

Declinations

For Maternal Child Health Rotations - Declination forms will NOT be accepted from students or instructors for any reason including medical, personal or religious.

Mandatory Forms

Completing the mandatory forms for submission to the Nursing Education & Professional Development Department

SUBMITTING THE MANDATORY FORMS *Once cleared by Employee Health Department*	
Send to: **Nursing Education & Professional Development Department** SB-Students@kp.org	**DEADLINE:** **3 weeks before start date**
For **student groups**, the ***Instructor*** must scan and submit a single PDF file of the following **MANDATORY FORMS** to **SB-Students@kp.org** for all students in the rotation. For **individual students**, you must scan and submit a single PDF file of the following **MANDATORY FORMS** to **SB-Students@kp.org** for your rotation or internship.	

NOTE: SUBMITTING THE REQUIRED FORMS & DOCUMENTATION MUST BE IN THE ORDER BELOW. ALL SCHOOLS ARE ALSO RESPONSIBLE FOR ENSURING THAT ALL DOCUMENTS ARE CURRENT.

	Forms	Pages
Any instructor accompanying students in the medical center must include the following forms in their packets:		
1.	Orientation Verification for Faculty	**3 pages**
2.	Nursing License Verification (via Breeze)	
3.	Individual Student Orientation Verification Form	**2 pages**
4.	Form 2860 - Child Abuse Reporting Requirements	**1 page**
5.	Form 2950 - Elder and Dependent Abuse Reporting Requirements	**1 page**
6.	Form 2870 - Confidentiality Agreement	**3 pages**
7.	Form 2862 - Drug-free Workplace Employee Acknowledgement	**2 pages**
8.	Compliance Training/HIPPA and Security Program	**1 page**
9.	KP HealthConnect Confidentiality and Non-Disclosure Agreement	**1 page**
10.	MCW #1128 – Dress Code Attestation Form	**1 page**
11.	Drug Screen	
12.	Background Check	
13.	Copy of BLS Card (front & back) – **For placements involving direct patient care**	
14.	KPLearn Modules – Certificate of Completion	

Drug Screening

All students and faculty are required to complete the urine drug screening and criminal background check in an effort to promote a culture of safety at Kaiser Permanente

Policies & Procedures

A 10-Panel Urine Drug Screening should be tested on all students and faculty.

Per the KP Southern California Regional policy, we require a test of the following substances: **Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Methadone, Opiates, Oxycodone, Phencyclidine (PCP), Propoxyphene, & Tetrahydrocannabinol (THC).**

Some acceptable drug screening companies that schools typically use are through:

CastleBranch

Quest Diagnostics™

LabCorp

Under the Influence

If a student or faculty shows signs of being under the influence during their student placement at South Bay Medical Center, the incident must be immediately reported to:

- School/Faculty
- KP Department Manager or designee
- Academic Liaison, SB-Students@kp.org

The individual will be escorted out of patient care areas by security and will NOT be allowed to return to ANY Kaiser Permanente facility.

Criminal Background

Policies & Procedures

Criminal Background Checks must include:

- Verification of legal name
- Verification of Social Security number
- Verification of address
- Seven years of residence/background/criminal history in residing counties
- Sex offender database search
- Felony and misdemeanor criminal record search
- Federal criminal record search
- Search through applicable professional certification or licensing agency for infractions if student holds professional license or certification

If criminal records are found:

- School representative **must disclose** results to the Academic Liaison
- Not always automatic exclusion
- **The Academic Liaison and KP South Bay Human Resources Department** will request to see the report to review records found
- The Academic Liaison will notify the school/instructor if the student is cleared to start clinical rotation

Excluded from ALL Kaiser Permanente Southern California rotations

Any faculty or student who is unable to complete or pass applicable screening requirements due to serious criminal convictions including, but not limited to:

- Murder
- Sexual offenses/sexual assault
- Felony possession and/or furnishing of a drug/controlled substance
- Felony theft
- Class B and Class A misdemeanor theft
- Fraud
- Felony assault
- Abuse
- Other felonies involving weapons and/or violent crimes

LIMITATIONS – *Criminal Background Check and Drug Screening*

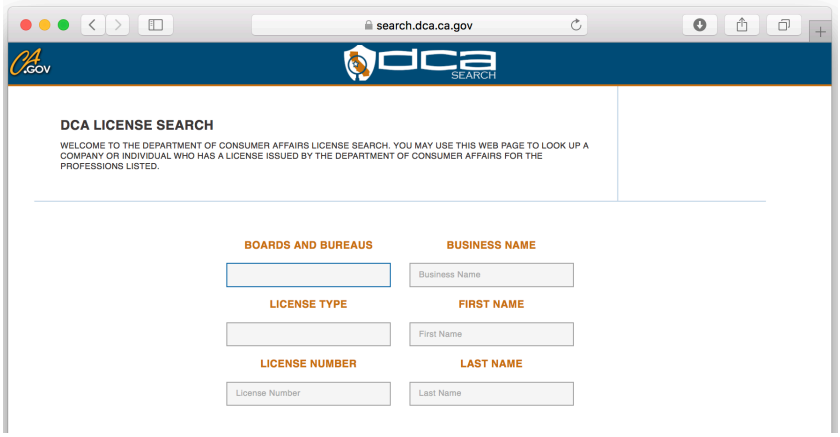
- Initial background check and drug screening satisfies screening requirements during continuous matriculation of the Faculty/student for the duration of their student placement
- If a faculty or student discontinues participation in the program for more than 1 consecutive semester, a new Background Check and Drug Screening must be submitted

License Verification

All students and faculty who are licensed healthcare professionals will be required to verify that the license to practice is current and active

BREEZE

- Medical professionals can verify their license by providing the Academic Liaison with his or her license number and Regulatory Board or by printing out the license verification page through Breeze.
- www.breeze.ca.gov



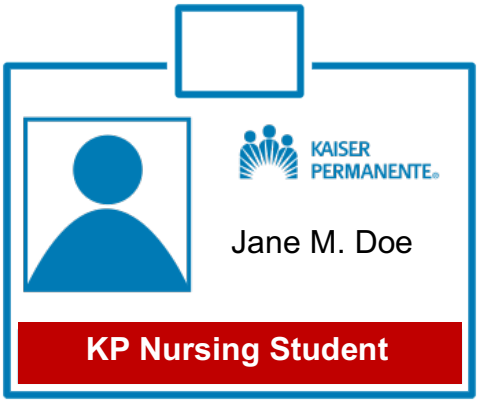
Student Clearance

CLEARANCE NOTIFICATION

- You will be notified via Email from SB-Students@kp.org (The Academic Liaison) when you have successfully submitted all your paperwork and has been verified by the Nursing Education & Professional Development Department

KP Badges

All students and faculty coming into the medical center will be mandated to have a KP South Bay badge present at all times while on the premises.



- Badges should be worn above the waist and seen clearly to identify the individual
- At the end of the rotation, students and faculty must return badges to the Security Department or Department Administrator; ***Failure to comply will result in loss of school contract.***

Obtaining KP Badges

For Student Groups:

- Once cleared by the Nursing Education & Professional Development Department, the instructor will need to complete the Badge Access form (see Appendix Q) for all students and will have the Department Administrator (DA) sign off the forms.
- The instructor will then schedule an appointment with Ana Olmedo (Ana.X.Olmedo@kp.org) from KP South Bay Security Department to submit the signed Badge Access Forms to obtain badges for students.

For Individual Students:

- Complete the Badge Access form and have the Department Administrator (DA) sign off the form.
- Go to security during business hours to obtain badge

Dress Code

Students and faculty rotating on the SBMC campus are required to adhere to our dress code policy.

Refer to Medical Center Wide (MCW) Policy #1128

Purpose

- To promote a professional image of staff
- To instill confidence with patients and families
- To ensure the safety of patients and staff

Review the Policy

- The MCW #1128 found in the Nursing Pathways page
- Ensure that compliance is maintained at ALL times when on KP South Bay Medical Center campus

Sign the Attestation

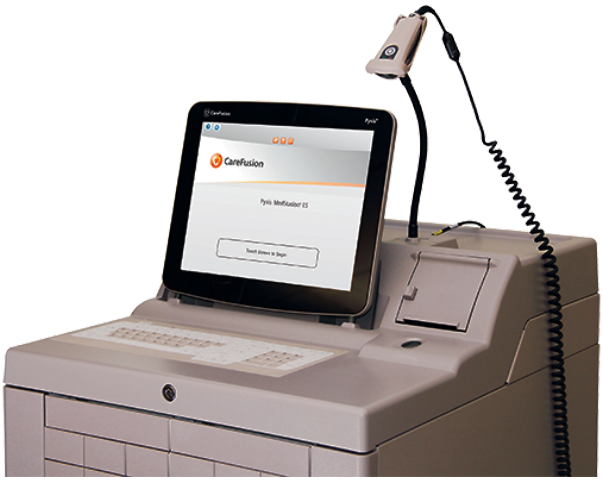
- Fill out the attestation form and submit with packet
- By signing the attestation form: you understand the policy and will comply at all times

Students and faculty who will be administering medications to patients will be required to gain Pyxis access.

Pyxis

For New Instructors:

1. The Unit Educator will communicate with the instructor on Kaiser South Bay Medical Center's Pyxis training and access requirements and also provide a unit specific orientation
2. The Unit Educator will train the instructor and complete the Pyxis competency form
3. The instructor will make an appointment to meet with the Unit Manager and submit the completed Pyxis competency form to him/her
4. The Unit Manager will keep the competency form and complete the Pyxis Access form and submit to Pharmacy
5. Pharmacy will grant access to the instructor but will restrict access to Narcotics



Scrub-Ex

Students and faculty rotating in L&D and the OR areas will be required to wear hospital-laundered scrubs

Students requiring hospital-laundered scrubs must:

- Contact Labor & Delivery or the Operating Room Nurse Managers to get access to the Scrub-Ex machine.
- Students will be required to return their hospital-laundered scrubs to the Scrub-Ex machine before they leave the medical center

Nova StatStrip

1. Instructors who have not been trained on the NovaStatStrip machine, please contact:

   Dennis Edora, Operations Area Lab Manager
   Telephone: 310-257-6334
   Email: Dennis.S.Edora@kp.org

2. Once instructors have been trained and validated as "Super Users", they will train their students on the Nova StatStrip machine using the machines on the unit of their clinical rotation. Instructors will complete the "Training and Competency Record POCT Glucose Testing using NOVA StatStrip" form for each of their students, and will fax copies to Dennis Edora. Original documents will be submitted to the Nursing Unit Educator.

3. Instructors who have been trained, need to complete their competency 6 months from the initial training and annually thereafter. Instructors will have access to the meters until the end of the rotation.

4. When an instructor returns for a new rotation, the meter will give an alert message if the instructor's competencies are due. The quizzes for the competency will be on the meter. The instructor will need to take the quiz and pass. If the instructor does not pass the quiz, he or she will not get access to the meter, and must contact Dennis Edora for further instruction.

Appendix

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development

REQUEST FOR AMBULATORY STUDENT PLACEMENT

Thank you for your interest for an ambulatory student placement at Kaiser Permanente South Bay Medical Center. Please complete and return this form to SB-Students@kp.org. Our department will review your application and determine if we are able to accommodate your request.

Student Name: _____ **Request Date:** _____

Name of College/University: _____

Degree Program: ☐ NP ☐ BHCA ☐ BSN ☐ MSN ☐ Other: _____

Name of Program: _____ **Course Name:** _____

Instructor Name: _____ **Contact #** _____

☐ Course Syllabus and Course Objectives (attach)

Student Placement Semester: ☐ Fall ☐ Spring ☐ Summer

Type of Request: ☐ Clinical ☐ Non-Clinical ☐ Leadership (1:1)

Identify required department(s) to complete student placement:

(1) _____ **# of required hours:** _____

(2) _____ **# of required hours:** _____

(3) _____ **# of required hours:** _____

(4) _____ **# of required hours:** _____

Provide your days and hours of availability for student placement:

DAYS	MON	TUES	WED	THUR	FRI
HOURS					

Start Date: _____ **Completion Date:** _____ **Expected Absences:** _____

To be completed by the Nursing Education & Professional Development Department:

Request Approved Date: _____ Date sent to Manager/DA/ADA or Provider preceptor: _____

Assigned Department(s): (1) _____ (2) _____ (3) _____

Submit three (3) months prior to start date.

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development

REQUEST FOR INPATIENT STUDENT PLACEMENT

Thank you for your interest in completing your rotation/preceptorship at Kaiser Permanente South Bay. Please complete and return this form to SB-Students@kp.org. Our student affiliate coordinator will review your application and determine if we are able to accommodate your application request.

Student Name: _____ **Request Date:** _____

Name of College/University: _____

Degree Program: ☐ ADN ☐ BSN ☐ MSN ☐ Other: _____

Name of Program: _____ **Course Name:** _____

Instructor Name: _____ **Contact #** _____ ☐ Course Syllabus Attached

Student Placement Semester: ☐ Fall ☐ Spring ☐ Summer

Type of Request: ☐ Clinical ☐ Non-Clinical ☐ Leadership (1:1)

Identify required unit(s) to complete student placement *(Inpatient Clinical Students ONLY)*: ☐ ICU/SDU
☐ 2000/3000 (Obs/Tele/Stroke) ☐ 3400 (Surgical/Ortho) ☐ 4200 (M/S Tele) ☐ 4300 (M/S Tele/Oncology/Stroke) ☐ ED
☐ Maternal Child Health (L&D/Post Partum/NICU)

Level of experience (Semester/quarter in program): _____ **Number of students:** _____

Instructor/student ratio (Max 1:10 for clinical rotation): _____

DAY	SUN	MON	TUES	WED	THUR	FRI	SAT
HOURS							
# of STUDENTS							

Instructor(s)	Contact No. & Email

Start Date: _____ **Completion Date:** _____ **Expected Absences:** _____

To be completed by the Nursing Education & Professional Development Department:

Request Approved Date: _____ Date sent to Manager/DA/ADA Provider preceptor: _____

Assigned Manager/Unit: _____

Only one clinical placement request per form. Submit *three (3) months* prior to desired start date.

Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development | Created 11/2017

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development

AMBULATORY SCHOOL AFFILIATES CHECKLIST

Packets should include all the following documents below in the specified order, scanned as one (1) pdf file, and emailed to **SB-Students@kp.org.**

1. Individual Student Verification Form (2 pages) – **DO NOT INCLUDE SUPPLEMENTAL DOCUMENTATION** (i.e. Immunizations, Titers, etc.)
2. Form 2860 - Child Abuse Reporting Requirements
3. Form 2950 - Elder and Dependent Abuse Reporting Requirements
4. Form 2870 - Confidentiality Agreement
5. Form 2862 - Drug-free Workplace Employee Acknowledgement (2 pages)
6. Compliance/HIPAA Security Program Form
7. KP HealthConnect Confidentiality and Non-Disclosure Agreement
8. Drug Screen (10 Panel, must include Tricyclics)
9. Background Check
10. Copy of BLS Card (front & back)
11. Completion the KP Learn Modules below and submit either a transcript or certificate of completion:
    - Click the link http://learn.kp.org/ to complete the mandatory online modules
    - Log on with your NUID and MyHR password

KP Learn Module Course	Time
General Compliance Training (current year)	1 hr
SCAL (current year) Annual: Safety & Environment of Care Training	45 min
Prevention of Workplace Violence	1 hr
Interacting with people with disabilities	30 min

Please Note: *Partial packets, forms out of order, or outdated forms **WILL NOT BE ACCEPTED** and will **DELAY** your start date.*

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development

INPATIENT SCHOOL AFFILIATES CHECKLIST

Please read the following instructions very carefully:

STEP ONE *Applies to Inpatient Clinical Placements only*	
Send to: **Deanna Suarez, Nursing Staffing Office** Deanna.R.Suarez@kp.org CC: SB-Students@kp.org	**DEADLINE:** **1 Month before start date**
Submit the **Common Provider Master (CPM)** form to gain access to KP HealthConnect and KP Learn and obtain a National User Identification (NUID) number.	

STEP TWO	
Send to: **Employee Health Department** EmployeeHealth-SouthBay@kp.org CC: SB-Students@kp.org	**DEADLINE:** **1 Month before start date**
Submit the **Student Health Screen Requirements Form & Interval Health Evaluation Questionnaire**. Also include any required supplemental documentation.	

STEP THREE *Once cleared by Employee Health Department*	
Send to: **Nursing Education & Professional Development Department** SB-Students@kp.org	**DEADLINE:** **3 Weeks before start date**
For **student groups**, the ***Instructor*** should scan and submit a single PDF file of the following **MANDATORY FORMS** (see page 2) to **SB-Students@kp.org** for all students in the rotation. For **individual students**, you must scan and submit a single PDF file of the following **MANDATORY FORMS** (see page 2) to **SB-Students@kp.org** for your rotation or internship.	

INPATIENT SCHOOL AFFILIATES CHECKLIST

PACKETS should include the following **COMPLETED** forms (in the following order below):

1. Individual Student Orientation Verification Form (2 pages) – **DO NOT INCLUDE SUPPLEMENTAL DOCUMENTATION** (i.e. Immunizations, Titers, etc.)
2. Form 2860 - Child Abuse Reporting Requirements (1 page)
3. Form 2950 - Elder and Dependent Abuse Reporting Requirements (1 page)
4. Form 2870 - Confidentiality Agreement (3 pages)
5. Form 2862 - Drug-free Workplace Employee Acknowledgement (2 pages)
6. Compliance/HIPAA Security Program Form (1 page)
7. KP HealthConnect Confidentiality and Non-Disclosure Agreement (1 page)
8. Drug Screen (10 Panel, must include Tricyclics)
9. Background Check
10. Copy of BLS Card (front & back)
11. Completion of and transcripts of the KP Learn Modules below:
    - Click the link http://learn.kp.org/ to complete the mandatory online modules
    - Log on with your NUID and MyHR password

KP Learn Module Course	Time
General Compliance Training (current year)	1 hr
SCAL (current year) Annual: Safety & Environment of Care Training	45 min
Prevention of Workplace Violence	1 hr
Safe Patient Handling (Hospital Initial Assignment CA only - current year)	1 hr
Interacting with people with disabilities	30 min
Mobility and Ambulation – SCAL	30 min
High Alert Medication Program (HAMP) Independent double check workflow (current year)	10 min
Pain assessment and management – SCAL	45 min

KP HealthConnect Training Module

KP Learn Module Course	Class ID	Time
KP HealthConnnect Inpatient Training for Nursing Students	00765490	4 hrs

If an Instructor is accompanying students in the units, they must include their own packet and the additional forms below (placed on top of the INSTRUCTOR's packet) with the student packets:

1. Faculty Verification Form (3 pages)
2. Nursing License Verification page (via Breeze)

Please Note: *Partial packets, forms out of order, or outdated forms **WILL NOT BE ACCEPTED** and will **DELAY** your start date.*

STEP FOUR *Once cleared by Nursing Education & Professional Development Department*	
Schedule an appointment with: **Ana Olmedo, KP South Bay Security Department** **Parking Lot 1, 1st Floor** Ana.X.Olmedo@kp.org	**DEADLINE:** **On or before start date after submission of checklist**
Instructors for student groups: Email Security with the list of student names, start and end date of rotation, and unit(s) the group will be rotating in and make an appointment to obtain KP badges. Office is open: M-F 8-12pm and 1-3:30pm.	

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Employee Health Services

STUDENT HEALTH SCREENING REQUIREMENTS

Student Name: _____ Date of Birth: _____ Unit/Dept: _____

School: _____ Rotation Start Date: _____ Rotation End Date: _____

Please enter **appropriate dates** and **provide written documentation**:

Tdap (Tetanus, Diphtheria, & Pertussis)	**Include:** Written documentation showing adequate vaccination or signed declination form	**Date of Vaccination:**	☐ **Declination Form** **Note:** Students entering MCH (L&D/Post Partum/NICU) or OB/Pediatrics may **NOT** decline Tdap. **No exceptions!**		
Seasonal Flu	**Include:** Written documentation showing adequate vaccination	**Vaccine Name:** **Lot #** **Exp. Date:**	**Date of Vaccination:**		
Rubeola (Measles)	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	**2nd Dose Given (>4 weeks later) Date:**	
Mumps	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	**2nd Dose Given (4 weeks later) Date:**	
Rubella (German Measles)	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**		
Varicella (Chickenpox)	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	**2nd Dose Given (4-8 weeks later) Date:**	
Hepatitis B	**Include:** Laboratory evidence of immunity or written documentation showing adequate vaccination or signed declination form	**Lab Evidence of Immunity Date:**	**1st Dose Given Date:**	**2nd Dose Given Date:**	**3rd Dose Given Date:**
		☐ **Declination Form**			
Tuberculosis (TB) Screening (PPD administered intradermally, results measured and recorded in millimeters induration at 48-72 hrs.)	**Negative PPD** (must include written documentation) ☐ non-reactive PPD **within last 12 months** _____mm of induration Date: _____ **AND** ☐ Second non-reactive PPD **within last 24 months** _____mm of induration Date: _____ **OR** ☐ non-reactive IGRA (QFT or T-spot) **within last 12 months**		**Positive PPD** (must include written documentation) ☐ Reactive PPD **and/or** INH Therapy _____mm of induration Date: _____ **AND** ☐ Negative Chest X-Ray Report **within 1 year of starting current Academic Program** Date: _____		

By signing below, I am attesting that the above information is accurate and can be made available to Kaiser Permanente at any time during this individual's clinical rotation.

School representative:

Name	Signature	Phone Number	Date
_____	_____	_____	_____

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Employee Health Services

INTERVAL HEALTH EVALUATION QUESTIONNAIRE

ATTENTION STUDENTS & FACULTY: Complete this form and submit to EHS if the student/faculty has a **HISTORY OF POSITIVE PPD**.
Complete this form, submit to EHS, and have a PPD done if the student/faculty has a **HISTORY OF NEGATIVE PPD**.

Name:_____ Date of Birth:_____

Age: _____ Sex: _____ Phone _____ Email _____

School:_____ Unit/Department:_____

Read the following carefully! All questions must be answered by all students/faculty whether they have a (-) or (+) PPD.

	YES	NO	QUESTION
1			Have you changed your last name since last year? If "Yes", give old:_____new:_____
2			Have you had any new problem, which currently is infectious or would prevent you from performing your assigned duties at this time? If "Yes", please describe:
3			Have you had an unexplained weight loss in the last year? If "Yes", give amount lost:
4			Do you have a persistent cough lasting 3 weeks or more?
5			Do you cough up blood?
6			Do you have persistent, unexplained fevers or night sweats?
7			Do you have a rash? If "Yes", for how long?
8			Have you seen a doctor for any of the above? If "Yes", which numbered item?
9			Do you have any reason to believe that your immune system may have been altered or damaged due to any of the following conditions or medications, which could increase your risk for tuberculosis (i.e. cancer; sarcoidosis; HIV/AIDS; chemotherapy; chronic steroid therapy or medications to prevent transplant rejection) ? ***Note: HIV infection and other medical conditions may cause a TB (PPD) skin test to be negative even when TB infection is present.***
10			If you have a positive TB test, do you also have any one of the following conditions (*you do not have to divulge your medical diagnosis):* part of your stomach removed, underweight/malnourished, infection with the AIDS virus or at risk for it, diabetes, silicosis lung disease, leukemia or lymphoma, kidney failure, head/neck cancer?
11			Have you completed the hepatitis B vaccine series? If "Yes" How many shots have you had? **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 have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself. However, I decline hepatitis B vaccination at this time. 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 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 at no charge to me. Sign below if you want to decline the Hepatitis B vaccine. _____ _____ Signature Date
12			Do you give/mix IV cytoxin (chemotherapy) drugs as part of your work assignment? If "Yes" How often?
13			Do you work with lasers? If "Yes" What type?
14			Have you had any skin or other reaction after contact with latex gloves or other latex products? If "Yes", have you been provided effective alternates to those products?: ☐ Yes ☐ No ***If you have any questions about hand care or latex allergies, please contact Employee Health Services.***

_____ _____ _____
NAME SIGNATURE DATE

EHS Staff/Licensed Provider Reviewer Name & Title	EHS Staff/Licensed Provider Reviewer Signature	Date

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development

INDIVIDUAL STUDENT ORIENTATION VERIFICATION FORM

STUDENT INFORMATION

Student Full Name _____

Student Telephone # _____ Student Email _____

Current/Previous Kaiser Permanente Employee? ☐ No ☐ Yes: Location & Dept. _____

Emergency Contact _____ Relationship _____ Telephone # _____

SCHOOL AFFILIATE INFORMATION

Affiliated School _____ Program _____

Clinical Hours Needed _____ Start Date of Rotation: _____ End Date of Rotation: _____

Faculty/Designee Name _____ Telephone # _____

Faculty/Designee Email _____

PRECEPTOR INFORMATION

Preceptor Name _____ Department/Facility _____

Telephone # _____ Email _____

REQUIRED DOCUMENTATION

1.	**Course Syllabus & Objectives**	**Provide Copy**
2.	**Professional License & Certification Verification**	**Provide Copy** if applicable
3.	**BLS – ACLS – PALS – NRP**	**Provide Copy** (provide what you have)
4.	**Criminal Background Check**	**Provide Copy** Date: _____
5.	**Drug Test (10-panel including Tricyclic Antidepressants)**	**Provide Copy** Date: _____

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

MMR Positive Titer or 2 Immunizations are **REQUIRED**	**Positive Titer Date:**	**Immunization #1 Date:**	**Immunization #2 Date:**	
Varicella Positive Titer or 2 Immunizations are **REQUIRED**	**Positive Titer Date:**	**Immunization #1 Date:**	**Immunization #2 Date:**	
Hepatitis B Positive Titer, 3 Immunizations, or Declination are **REQUIRED**	**Positive Titer Date:**	**Imm. #1 Date:**	**Imm. #2 Date:**	**Imm. #3 Date:**
Tuberculosis (TB) Positive TSTs are **REQUIRED** to provide a negative CXR report	**Last 12 Months:** **Result:** _____ mm	**Last 24 Months:** **Result:** _____ mm	**Negative Chest XRay Date:**	
Tdap	**Immunization Date:**			
Influenza (Flu) Vaccination **NO DECLINATIONS ARE ACCEPTED FOR ANY REASON**	**Immunization Date:**			
Hepatitis A (Dietary Students only)	**Immunization Date:**			

HEALTH SCREENING QUESTIONS	
Please answer the following 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 Students:		**Nurses/Nursing Students Only:**
☐ Student unpaid field experience and training policies and procedures	☐ Situation, Background, Assessment, & Recommendation (SBAR)	☐ Regional High-Alert Medication Safety Practices Polices & Procedures
☐ Affiliated Schools Criminal Background Check/Drug screening policies and procedures	☐ Guide to the principles of responsibility	☐ KP Nursing Professional Practice Model
☐ Drug-Free Workplace National HR policy	☐ Dress Code	☐ KP Vision & Values
☐ Current Ambulatory/Inpatient National Patient Safety Goals	☐ Five Compliance Expectations	☐ What is the Professional Practice Model?
☐ HIPPA 101: Privacy and Security Basics	☐ Prevent Fraud, Waste, and Abuse	☐ **Inpatient:** Nurse Knowledge Exchange Plus (NKE+)
		☐ **Inpatient:** Barcoding Scanning Medication Administration – Instructions for Students

I hereby affirm that the information I provide during the Orientation Verification process is accurate and fairly represents my understanding of Orientation 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. Any such misrepresentation, misstatement or omission, whether intentional or otherwise, may result in immediate suspension or termination of program participation with Kaiser Permanente. I understand my school may receive a copy of this completed form.

Student Name _____ Student Signature _____ Date _____

Faculty Name _____ Faculty Signature _____ Date _____

KP Academic Liaison Representative/Designee _____ Date _____

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development

ORIENTATION VERIFICATION FORM FOR FACULTY

COURSE INFORMATION
Orientation Date: _____ School: _____ Student Level: _____
Course Title: _____ Syllabus Provided? ☐ No ☐ Yes
Unit/Dept: _____ Start Date of Rotation: End Date of Rotation:

FACULTY INFORMATION
Faculty Name _____ Telephone # _____
Faculty/Designee Email _____
Emergency Contact _____ Relationship _____ Telephone # _____
Please complete the following: 1. Have you been a clinical instructor at Kaiser Permanente South Bay Medical Center before? ☐ No ☐ Yes 2. Have you been a clinical instructor at the assigned/designated unit/department before? ☐ No ☐ Yes

1.	**Professional License** ☐ RN ☐ Other:	Exp. Date: _____
2.	**Professional Certification** ☐ NP ☐ CNS ☐ Other:	Exp. Date: _____
3.	**AHA/BLS**	Exp. Date: _____
4.	**Criminal Background Check**	Date: _____
5.	**Drug Test (10-panel including Tricyclic Antidepressants)**	Date: _____

ORIENTATION DOCUMENTS (FACULTY PLEASE CHECK THE BOXES TO INDICATE REVIEW AND COMPLETION)	
☐ Form 2860 - Child Abuse Reporting Requirements	☐ Drug-Free Workforce Employee Acknowledgement Form
☐ Form 2950 – Elder and Dependent Abuse Reporting Requirements	☐ Compliance Training/HIPPA and Security Attestation Form
☐ Confidentiality Agreement Form	☐ KP HealthConnect Confidentiality and Non-Disclosure Agreement Form

REQUIRED HEALTH SCREENING (FACULTY PLEASE CHECK THE BOXES ONLY IF APPLICABLE)	
☐ Tetanus, Diphtheria, Typhoid (Tdap)	☐ Hepatitis A (for Dietary only)
☐ MMR	☐ Hepatitis B
☐ Tuberculosis (TB)	☐ Varicella
☐ Seasonal flu	

KAISER PERMANENTE®

Kaiser Permanente South Bay Medical Center – Nursing Education & Professional Development

ORIENTATION VERIFICATION FORM FOR FACULTY

REQUIRED READING (FACULTY PLEASE CHECK THE BOXES TO INDICATE REVIEW AND COMPLETION)		
All Students:		**Nurses/Nursing Students Only:**
☐ Student unpaid field experience and training policies and procedures	☐ Situation, Background, Assessment, & Recommendation (SBAR)	☐ Regional High-Alert Medication Safety Practices Polices & Procedures
☐ Affiliated Schools Criminal Background Check/Drug screening policies and procedures	☐ Guide to the principles of responsibility	☐ KP Nursing Professional Practice Model
☐ Drug-Free Workplace National HR policy	☐ Dress Code	☐ KP Vision & Values
☐ Current Ambulatory/Inpatient National Patient Safety Goals	☐ Five Compliance Expectations	☐ What is the Professional Practice Model?
☐ HIPPA 101: Privacy and Security Basics	☐ Prevent Fraud, Waste, and Abuse	☐ **Inpatient:** Nurse Knowledge Exchange Plus (NKE+)
		☐ **Inpatient:** Barcoding Scanning Medication Administration – Instructions for Students

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: **Deanna R. Suarez**	☐ Health & Safety Verification Form ☐ Medical Center Specific website items

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

I verify that I meet all the requirements defined by policy. I verify that student(s) listed below meet all the requirements defined by policy.

Faculty Name _____ Faculty Signature _____ Date _____

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2860 **CHILD ABUSE REPORTING REQUIREMENTS** Page 1 of 1

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

Submit

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit buttion.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

2860 11/21/2006 11 Page 1 of 1

KAISER PERMANENTE®

2950 ELDER AND DEPENDENT ADULT ABUSE REPORTING REQUIREMENTS

Page 1 of 1

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. 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	

Submit

After completing the form:
1. Print form to keep a copy for your records.
2. Press the Submit buttion.
3. Wait for a pop-up screen to confirm the form has been submitted. (This may take a few minutes.)

National HR Service Center
Fax to: (877) 477-2329
Telephone: (877) 457-4772

2950 11/21/2006 13 Page 1 of 1

Next Page >

KAISER PERMANENTE®

2870 **CONFIDENTIALITY AGREEMENT** Page 1 of 3

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 National HR Service Center, Alameda.
3. Remember to print copy of form before submitting.
4. 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, CONTRACTORS (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 elses 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.

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

2870 NCAL-SCAL 07/08/2014 17 Page 1 of 3

Next Page >

KAISER PERMANENTE®

2870 **CONFIDENTIALITY AGREEMENT**

* 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.

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

< Previous Page

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)

Submit

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 National HR Service Center (877) 477-2329 or interoffice mail to National HR Service Center, Alameda.

KAISER PERMANENTE®

2862 **DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT** Page 1 of 2

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 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)

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

2862 04/15/2011 4 Page 1 of 2

Next Page >

KAISER PERMANENTE®

2862 **DRUG-FREE WORKPLACE - EMPLOYEE ACKNOWLEDGEMENT**

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

KAISER PERMANENTE®

FACILITY: _____

TITLE: Compliance / HIPAA Security Program

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

Your Information		
LAST NAME	FIRST NAME	MIDDLE INITIAL
NUID #		
Primary Phone #	Alternate Contact #	
NURSING UNITS:	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, have completed the **General Compliance for Students.**

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 school liaison or the clinical site Nursing manager.
- 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

Revised 11/12/08
408078 v3

Work Order Number for KPHC Access Request:	
REQUESTING MANAGER NAME:	
MANAGER NUID:	
NCOA BUSINESS UNIT:	
NCOA GL LOCATION:	
NCOA DEPARTMENT:	
Manager's Phone including Area Code:	
KPHC Security Template: USE CHECK BOX ON WORKSHEET #3 to incidate template needed	

STUDENT INFORMATION — Please note that all of the info under the green colored headers need to be filled out by the school

Delete these columns when submitting to KPHC

NUID	School	FIRST NAME	MI	LAST NAME	Gender	SSN (Full) [delete when submitting to KPHC]	Date of Birth (mm/dd/yyyy) [delete when submitting to KPHC]	Type of Student Program	Job Title	KAISER EMPLOYEE Y OR N	FACILITY NAME	Unit	Rotation Days (e.g. Mon/Thurs)	Start Date of Rotation	End Date of Rotation	Preceptor Name (IF KNOWN)	Preceptor's Phone # (IF KNOWN)	Resource ID (CPM USE ONLY)	NCOA GL LOCATION	NCOA DEPARTMENT	SUB DEPT / MODULE

INSTRUCTOR INFORMATION

NUID	School	FIRST Name	MI	LAST Name	Gender	SSN (Full) [delete when submitting to KPHC]	Date of Birth (mm/dd/yyyy) [delete when submitting to KPHC]	LICENSE # (RN, LVN, etc)	Job Title	KAISER EMPLOYEE Y OR N	FACILITY NAME	Unit	Rotation Days (e.g. Mon/Thurs)	Start Date of Rotation	End Date of Rotation	Instructor Contact Phone Number	Instructor Contact email	Resource ID (CPM USE ONLY)	NCOA GL LOCATION	NCOA DEPARTMENT	SUB DEPT / MODULE

Note: Form is in a Microsoft Excel Spreadsheet format.

KAISER PERMANENTE- South Bay	POLICY & PROCEDURE
Title: **Dress and Personal Appearance**	**Policy #:** **MCW 1128**

EXHIBIT A

ACKNOWLEDGEMENT

DRESS AND PERSONAL APPEARANCE POLICY

I have received, read, and understood the Kaiser Permanente South Bay Medical Center Dress and Personal Appearance Policy, and have had the opportunity to discuss it with my manager.

_____
Employee Number

_____	_____	_____
Employee Signature	Print Name	Date

_____	_____	_____
Manager Signature	Print Name	Date

New Photo ☐

KAISER PERMANENTE®
Medical Care Program
Southern California Region

TRI-CENTRAL SERVICE AREA
SECURITY SUPPORT SERVICES
Identification Badge & Vehicle Registration

IDENTIFICATION BADGE (Please Print)

First Name	Last Name	Middle Name	Employee #

Job Title	Practitioners License Status and/or Vocational Classification	Department	Location	Tie-line & Ext.

Transfer	Yes ☐ No ☐	**Previous Facility:**		
New Hire:	Yes ☐ No ☐	**Re-Hire:**	Yes ☐ No ☐	

Department Administrator/DA (Please Print)	DA's Ext.
Status (ie: Staff, Associate, Per-Diem, etc.)	

VEHICLE (S) INFORMATION

Year	Make	Model	Color	License Plate

Do you require a parking stall or space designated for disabled persons or disabled veterans?	Yes ☐ No ☐	**Are any of the vehicles listed above taller than 6' 10"?**	Yes ☐ No ☐

Have you been issued any Medical Center or MOB door keys	Yes ☐ No ☐			
If Yes, in the spaces provided list the individual key number stamped on each key in your possession (ex. 1AMD4, 4OBG27, 1ORT16, etc)				

For Dept. Manager or Supervisor use only:

☐ Bilingual Required Position -- Language _____

Dept. Manager Signature: _____ **Date** _____

I hear by acknowledge that I have read and understood the Kaiser Permanente (KP) ID Badge and Parking policies.

- I must comply with ***Title 22*** regulations, which state: ***All employees of the hospital having patient contact, including students, interns and residents, shall wear an identification tag bearing their name and vocational classification.***
- I must comply with Kaiser Permanente Identification Badge Policies, by wearing my I.D. card at all times while on duty. The card is to be worn on the front upper half of the body with the name clearly visible. I also understand that this card is Medical Center property and must be turned in to personnel office upon termination of employment or upon request of management.
- I must comply with the Parking Policy, by parking in the appropriate designated area and by updating vehicle information as necessary. I also must turn in my parking hang-tag upon termination of employment and or at the request of Security, Human Resources and or KP Administrative staff.
- I understand that Kaiser Permanente does not assume responsibility for lost, stolen or damaged vehicles or personal property left in parking areas.

Signature: _____ **Date** _____

FOR OFFICE USE ONLY

Employee ☐ Contractor ☐ Consultant ☐ Volunteer/Student ☐ Perinatal ☐

Issued By: Date Issued: Temporary ☐ Replacement ☐

Key Card #: **ID Badge #:** **Parking Permit #:**

W/form/I.D. form 02/07/181:32 PM