

## Agency/Contract Staff Attestation Statement

### Instructions

- Please print this page
- Read through each policy and training available online
- Check each box and sign
- Please return to Department Manager or Staffing Office, as applicable

### Infection Prevention

- ☐ This is to certify that I understand that due to the nature of the healthcare environment I may be exposed to potentially harmful or infectious risks. It is my responsibility to review department safety procedures with the department manager or designee and to bring all questions and concerns to the attention of my SHS site contact. It is also my responsibility to follow all safety procedures, as outlined in my orientation.

### Policies

- ☐ This is to certify that I have read and understand the following policies. I further certify that I will follow them during my time working at Samaritan Health Services. I also understand that it is my responsibility to bring any questions I may have regarding these policies and procedures to the attention of my SHS site contact.

#### SHS Policies

- ☐ Samaritan Code of Conduct & Business Ethics Policy
- ☐ Confidential and Proprietary Information Policy
- ☐ Tobacco Free Campus Policy
- ☐ Drug and Alcohol-Free Workplace
- ☐ Workforce Information Technology Use Policy
- ☐ Discrimination & Harassment Free Workplace Policy - System
- ☐ Workplace Safety & Violence Reduction Policy
- ☐ Rights and Responsibilities of Patients, Guardians and Health Care Representatives

### General Training

I have read and understand the following Online Trainings:

- |  |  |
|--|--|
| <input type="checkbox"/> Cultural Humility Training              | <input type="checkbox"/> Safety Training                                     |
| <input type="checkbox"/> Information Privacy & Security Training | <input type="checkbox"/> Discrimination & Harassment-Free Workplace Training |
| <input type="checkbox"/> COVID-19 Workplace Precautions          | <input type="checkbox"/> COVID-19 Exceptional Risk Training                  |
| <input type="checkbox"/> POCT Training Module (if applicable)    |  |

### Confidentiality Statement/HIPAA

Medical records and hospital information are confidential for the protection of patients, families, employees, medical staff, students, and the hospital. Confidential information includes any information that a worker hears or sees while conducting work activities at a Samaritan Health Services facility. Patient privacy is to be respected at all times. Breach of confidence is cause for immediate termination of the individual's affiliation with Samaritan Health Services. My signature below indicates the following:

- I agree not to repeat or discuss, with any unauthorized individuals, confidential information, which I may see or hear while working at a Samaritan Health Services' facility.
- I agree not to obtain or distribute any originals or copies of Samaritan Health Services' and/or its facilities' documents that are considered confidential or part of a patient's medical record.
- I understand that breach of confidence is cause for immediate termination of my educational or clinical affiliation with Samaritan Health Services.
- I understand that unauthorized release of confidential information may subject me to civil liability under the provisions of state and federal laws.

By signing below, I have acknowledged that I have received and read the above materials and policies. I agree to act in full compliance with the principles and policies stated therein. I understand that these policies may be added to or changed by SHS at any time. It is my responsibility to bring any questions I have about these policies to my site contact or the appropriate offices. I further understand that it is my responsibility to report any violations of these policies that I witness or become aware of during the course of my assignment at SHS.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_