Schools of Nursing Student and Instructor Receipt Verification
General Orientation Manual Non Associates & Clinical Affiliations

Name: ____________________________ Date: ____________________________

School: ____________________________ Semester/Term: ____________________________

School of Nursing Instructor/Clinical Coordinator: ____________________________

St. Vincent’s Facility: ____________________________ Clinical Unit: ____________________________

The online General Orientation Manual Non Associates & Clinical Affiliations will provide you with a
general understanding of the hospital policies and guidelines. The information contained in this online
orientation manual should be helpful, and you are required to become familiar with its contents.

This online manual does not cover every question about your clinical rotation, and is not a contract.

Your signature confirms your online access to this manual, and your understanding that it is your
responsibility to familiarize yourself with its content.

*I understand that should I have any questions regarding information contained in this handbook, or
other policies, it is my responsibility to consult with my preceptor and/or clinical liaison.*

The following information must be completed accurately and completely prior to beginning your clinical
rotation. All personal information is required for access to in-house computer systems and will be
treated confidentially.

<table>
<thead>
<tr>
<th>Last Name (printed):</th>
<th>First Name (printed):</th>
<th>Middle Initial:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Date of Birth (day and month only):</th>
<th>Last 4 of Social Security Number:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Mailing Address:</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Email Address:</th>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Phone Number:</th>
<th>Cell Phone Number:</th>
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</table>

<table>
<thead>
<tr>
<th>Name of Emergency Contact:</th>
<th>Relation to Emergency Contact:</th>
<th>Phone Number(s) of Emergency Contact:</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Signature: ____________________________ Date: ____________________________
St. Vincent’s Health System

Schools of Nursing Orientation Test

Name: ____________________________ Date: ____________________________

School: ___________________________ Semester/Term: ___________________

School of Nursing Instructor/Clinical Coordinator: ___________________________

St. Vincent’s Facility: ___________________________ Clinical Unit: ___________________

Match the following Emergency Codes to the appropriate description by placing the letter in the box.

<table>
<thead>
<tr>
<th>Answer</th>
<th>Emergency Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>White</td>
<td>A. Infant Abduction</td>
</tr>
<tr>
<td>2.</td>
<td>Red</td>
<td>B. Fire</td>
</tr>
<tr>
<td>3.</td>
<td>Blue</td>
<td>C. Adult cardiac or respiratory arrest</td>
</tr>
<tr>
<td>4.</td>
<td>Adam</td>
<td>D. Infant/Child cardiac or respiratory arrest</td>
</tr>
<tr>
<td>5.</td>
<td>Gray</td>
<td>E. Bomb threat</td>
</tr>
<tr>
<td>6.</td>
<td>Black</td>
<td>F. Severe weather</td>
</tr>
</tbody>
</table>

7. The number to call to report a fire is ________________, and the number to call to report a cardiopulmonary arrest is ____________.

8. St. Vincent’s Health System’s policy requires that all associates, as well as nursing students and instructors, wear the appropriate identification. This is done by wearing the school identification badge.
   A. True   B. False

9. All blood sugar results must be reported to the appropriate staff nurse, as well as any treatment administered.
   A. True   B. False

10. All patient information is considered protected and should not be discussed in public areas, even within the hospital. All paper with patient information must be discarded in the appropriate shredder bin on the unit.
    A. True   B. False

11. The two patient identifiers used by St. Vincent’s Health System facilities patient care associates for medication administration and blood administration are:
    A. Patient Name
    B. Patient Date of Birth
    C. Medical Record Number
    D. Local Zip Code
    E. A & B
    F. All of the above
HIPAA Privacy and Security Agreement & Acknowledgement

As an associate or non associate of St. Vincent's Health System, I commit to maintaining confidentiality in accordance with hospital policies and the law.

I will:
- Take patient privacy seriously
- Maintain the confidentiality of patients' protected health information (PHI)
- NEVER share my password
- Only access PHI that I have been authorized by STVHS to access
- Disclose PHI to the appropriate individual or entity if necessary for the treatment of a patient
- Disclose PHI to the appropriate individual or entity to the minimal extent necessary to facilitate payment or hospital operations
- Disclose PHI at the direction of only physicians involved in the patient's care
- Complete all required training by end of each year
- Know STVHS HIPAA and HITECH Policies
- Abide by hospital policies governing the use of hospital computers as outlined in the Acceptable Use Policy and internet access as outlined in the Internet Usage Policy
- Seek advice when unsure of how HIPAA applies to a situation
- Refer patients that ask for copies of their medical records to the Health Information Management (HIM) department
- Never directly access my relatives, my friends and even my own medical information
- Contact Health Information Management to obtain my medical Information
- Be sure STVHS Official PHI Fax Coversheet accompanies all faxed PHI
- Make sure computer screens containing PHI are not accessible to the public view
- Report all HIPAA violations and suspected-violations immediately to the Corporate Responsibility Office
- Report privacy and security concerns to the STVHS Privacy Officer/Information Security Officer, STVHS Management or via STVHS-Ascension Health Values Line (800-707-2198 or www.ascensionhealthvaluesline.org)

I have read, understand, and agree that as an associate or agent employed by St. Vincent's Health System, I am committed to uphold the highest standard of individual ethical and legal business practices as outlined in STVHS Standards of Conduct. I also understand that knowingly disclosing PHI contrary to the protections as provided by the Health Insurance Portability and Accountability Act of 1996 (as amended) may result in immediate termination and I may be held accountable in a court of law, fined up to $50,000 per disclosing instance and receive up to 10 years imprisonment. In addition, any violation may result in appropriate disciplinary action, including termination and/or removal of non associate.

Name (Print Clearly) ___________________________ Signature: ___________________________ Date: ___________________________

Check Applicable Health Ministry
☐ STV Birmingham  ☐ STV East  ☐ STV Blount  ☐ STV St. Clair  ☐ STV 119  ☐ STVHS
St. Vincent’s Health System and affiliates is dedicated to the highest standard of moral and ethical excellence. Fostered from the Organizational Code of Ethics, St. Vincent's Health System and affiliates obtain this standard by requiring the associate to maintain a high standard of Corporate Responsibility. As an associate or agent of St. Vincent's Health System and affiliates, I will be committed to the following Standards of Conduct:

**Quality of Care** - Provide competent and compassionate care, respect and safeguard the dignity of the patient, and allow patients' access to all the medical and ethical information necessary to make decisions about their care.

**Laws and Regulations** - Operate in accordance with all laws and regulations.

**Human Resources** - Cultivate a work environment where all associates are highly regarded.

**Business and Ethical Practices** - Not purposely defraud anyone of money, property, or services and preserve and protect the organizational assets: physically, electronically and intellectually.

**Conflicts of interest** – Never use my position or status at St. Vincent's Health System to profit personally or to assist others in profiting in any way at the expense of the organization.

**Confidentiality** - Maintain the confidentiality of medical records and other patient information, known as Protected Health Information (PHI); as well as keep confidential information about other associates and proprietary business practices of the organization to include the security of information and electronic systems, known as Proprietary Information.

I have read, understand, and agree that as an associate or agent employed by St. Vincent’s Health System and affiliates I am committed to uphold the highest standard of individual ethical and legal business practices. I will not tolerate illegal or questionable activity and promise to take whatever steps are required by the Corporate Responsibility Program to identify, report, and prevent such activity.

I also have received the Standards of Conduct and agree to follow them. I understand that compliance with the Standards of Conduct and the Corporate Responsibility Program is a condition of my continued employment or association with St. Vincent's Health System and affiliates. I will abide by the principles stated in this document and all related policies. I further understand that as an associate of St. Vincent's Health System and affiliates, any violation may result in appropriate disciplinary action including possible termination.

Name (Print Clearly)          Signature:                  Date: